Connecticut

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/14/2017 12.22.30 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 103626086

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

Mailing Address P.O. Box 341431 410 Capitol Avenue

City Hartford

Zip Code 06134

Telephone 860-418-6676

Fax 860-418-6691

Email Address Miriam.Delphin-Rittmon@ct.gov

State CMHS DUNS Number

Number 103626086

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Department of Mental Health and Addiction Services

Organizational Unit

Mailing Address 410 Capitol Avenue, MS# 14COM

City Hartford

Zip Code 06134

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Miriam

Last Name Delphin-Rittmon

Agency Name Department of Mental Health and Addiction Services

Mailing Address 410 Capitol Ave

City	Hartford
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Telephone	860-418-6676
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Email Address	Miriam.Delphin-Rittmon@ct.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Susan
Last Name	Bouffard
Telephone	860-418-6993
Fax	860-418-6896
Email Address	susan.bouffard@ct.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Title

Organization

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Children's plan Step I
Asses the strengths and needs of the service system to address the specific populations. Include a discussion of the current service system's attention to the priority population children with SED.
Section I State Information

Overview
Connecticut
Geographically, Connecticut is a small state and is ranked 48th in size by square area with approximately 5,500 square miles. However, Connecticut is the 29th most populated state with a total population of about 3,576,500, and about 761,795 or 21.3% are children and youth under the age of eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, data from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) would indicate approximately 10% of Connecticut children are in need of mental health services in Connecticut. (20% may have behavioral health symptoms).

Finally, 80.8% of residents are white, 11.6% are black, .5% are American Indian or Native Alaskan, 4.6% Asian, .1% Native Hawaiian and other Pacific Islander, and 2.2% of residents report 2 or more races and 15.4% of the general population is Hispanic. Census data from 2015 denotes a median household income of $70,331 with 10.5% of residents living in poverty. The contrast in Connecticut is of some of the largest gaps between the richest and poorest residents.

The Department of Children and Families
Working together with families and communities to improve child safety, ensure that more children and youth have permanent families, and to advance the overall well-being of children, youth and families is the central focus of the Department of Children and Families (DCF). DCF protects children who are being abused or neglected, strengthens families through support and advocacy, and builds on existing family and community strengths to help children and youth who are facing emotional and behavioral challenges, including those committed to the Department by the juvenile justice system.

DCF, established under Section 17a-2 of the Connecticut General Statutes, is one of the nation's few agencies to offer child protection, behavioral health, juvenile justice and prevention services. This comprehensive approach enables DCF to offer quality services regardless of how a child's problems arise. Whether children and youth are abused and/or neglected, are involved in the juvenile justice system, or have emotional, mental health or substance use issues, the Department can respond to these children and youth in a way that draws upon community and state resources to help.

DCF recognizes the importance of family and strives to support children and youth in their homes and communities. When this is not possible, a placement that meets the child's individualized treatment needs in the least restrictive setting is pursued. When

services are provided out of the child's home, whether in foster care, residential treatment or in a DCF facility, they are designed to return children safely and permanently back to the community.

DCF supports in-home and community-based services through contracts and agreements with service providers. In addition, the Department runs four facilities:

> ***The Connecticut Juvenile Training School***, a secure facility for boys who are committed to the Department as delinquents by the juvenile courts (slated to be closed in 2018);
>
> The ***Albert J. Solnit Psychiatric Center*** has a North and South campus that serve children with complex serious emotional disturbances. The North Campus in East Windsor, has a Psychiatric Residential Treatment Facility (PRTF) with two units for males. The South Campus located in Middletown has both inpatient units for males and females and a PRTF that serves females;
>
> ***The Wilderness School***, a prevention, intervention, and transition program for adolescents from Connecticut. The program is supported by the State Department of Children and Families (DCF) in addition to a tuition fee program utilizing a significant private funding base. The Wilderness School offers high impact wilderness programs intended to foster positive youth development.
>
> Designed as a journey experience, the program is based upon the philosophies of experiential learning and is considered therapeutic for the participant. Studies have documented the Wilderness School's impact upon the self-esteem, increased locus of control (personal responsibility), and interpersonal skill enhancement of adolescents attending the program experiential program for troubled youth.

Behavioral Health Assessment and Plan – Children's Services

Organizational Structure - State Level (DCF)

The Department has five mandated areas which include child welfare, children's behavioral health, education, juvenile services and prevention. In addition to the operated facilities, the Department consists of a Central Office and fourteen Area Offices that are organized into six regions. At any point in time, the Department serves approximately 26,000 children and 12,000 families across its programs and mandated areas of service. The average number of full-time employees is 3,357. DCF's recurring operational expenses total around $793,380,378.

DCF's mission statement: ***"Working together with families and communities for children who are healthy, safe, smart and strong."***

SEVEN CROSS-CUTTING THEMES: The following seven cross-cutting themes shall guide all DCF operational units in advancing the mission and strategies of the agency:

- implementing strength-based family policy, practice and programs;
- applying the neuroscience of early childhood and adolescent development;
- expanding trauma-informed practice and culture;
- addressing racial inequities in all areas of our practice;
- building new community and agency partnerships;
- improving leadership, management, supervision and accountability; and
- becoming a learning organization.

DCF STRATEGIES: Informed by the cross-cutting themes, DCF shall implement the following strategies to advance the well-being of children and their families in accordance with the DCF mission:

- increase investment in prevention and health promotion;
- apply strength based family-centered policies, practice and supports agency wide;
- develop and expand regional networks of in-home and community services;
- ensure appropriate us of congregate care;
- address the needs of specific populations;
- support collaborative partnerships with community and other state agencies;
- support the public and private sector workforce;
- increase the capacity of DCF to manage ongoing operations and change; and
- improve revenue maximization and develop reinvestment priorities and methods.

This mission is grounded in a core set of beliefs that encompass the Department's vision for how to provide services to Connecticut's children and families. We believe that children do best when living safely at home with their family of origin. When living at home with a parent is not reasonably safe, the best alternative is to live with another family member who can provide a safe and nurturing home. If no family member can provide a suitably safe home that meets the child's needs, the child should receive care and services in an appropriate foster home until timely permanency can be achieved through reunification, transfer of guardianship or adoption. Foster care should only be used as a short-term intervention. While in foster care, regular and ongoing contact with parents and siblings is maintained. Finally, all youth are to exit the Department's care with legal and/or relational permanency.

Congregate care, such as group homes and residential treatment centers, should not be used for the vast majority of children. They are designed to address specific treatment needs. For older youth, treatment in congregate care is s expected to be used in a targeted manner with extensive family involvement in the treatment process.

Services should be individualized and based on a full assessment of the strengths and needs of children and families. This assessment must be made together with family members and children, in an age and developmentally appropriate manner. A full assessment is inclusive of safety, risk, domestic violence, substance use, criminogenic needs, medical, dental, educational and mental health needs. The goal of these individualized services is to enable the child to do well and thrive, living in the family home of a parent, family member or another permanent family.

The DCF mission statement mirrors SAMHSA's four major dimensions that support a life of recovery - health, home, purpose and community.

The structure of DCF consists of the Commissioner who has a Deputy Commissioner of Operations, a Chief of Quality and Planning, a Deputy Commissioner of Administration, six Regional Administrators, a Chief of Staff and the Facility Superintendents who all have direct report to the Commissioner.

Role of the State Mental Health Agency for Children: Connecticut Department of Children and Families

Statutory Authority:

The Connecticut Department of Children and Families (DCF) has statutory authority to provide for children's mental health services in the state. With this statutory mandate DCF plays a key leadership role in both providing mental health services for children, youth and families across Connecticut, and in developing, planning, coordinating and overseeing children's mental health services.

Children's Behavioral Health Plan:

Following the tragic events that occurred in Newtown Connecticut on December 14, 2012, the Connecticut General Assembly passed Public Act 13-178 which specifically directed DCF in partnership with identified stakeholders to produce a children's behavioral health/mental health plan for the state of Connecticut. The public act pushed Connecticut to focus fully on child and family mental health and well-being. As of 2015 there were 761,795 or 21.3% children and youth under the age of eighteen. Epidemiological studies suggest that as many as 20% of that population (10% may have

SED), or over 150,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment. However, many of these children are not able to access services. Public Act 13-178 is intended to address this and related children's mental health issues.

The public act required the behavioral health/mental health plan to be comprehensive and integrated and meet the behavioral and mental health needs of all children in the state, and to prevent or reduce the long-term negative impact for children of mental, emotional, and behavioral health issues. The public act specifically focused on addressing the following areas:

- Identify, prevent, address and remediate the mental, emotional and behavioral health needs of all children within the State of Connecticut
- Coordinate and expand services that provide early intervention for young children, specifically home visiting services and the CT Birth to Three program
- Expand training in children's mental, emotional and behavioral needs for school resource officers, pediatricians, child care providers and mental health professionals
- Understand whether the lack of appropriate treatment for children and young adults may lead to placement within the youth or adult justice systems
- Seek funding for public and private reimbursement for mental, emotional and behavioral health services

DCF contracted with the Connecticut Child Health and Development Institute (CHDI) and other stakeholder partners, to help develop the children's behavioral health/mental health plan by:

- Obtaining input from consumers, families, content experts, and other state and local stakeholders through family focus groups, facilitated discussions on specific topics and public forums
- Collecting, analyzing, and synthesizing data and information about the strengths and weaknesses of the current system and current services
- Developing a written plan for the State that will guide the ongoing development of a comprehensive and effective children's mental health system

The behavioral health/mental health plan developed out of this process resulted in seven broad thematic areas, each with specific goals and strategies for significantly improving Connecticut's children's behavioral health/mental health service system. The Plan includes a proposed timeline for implementation that focuses on the development

of the infrastructure and the planning of the array of services that will comprise the System of Care. The seven broad themes identified in the plan are:

- System Organization, Financing and Accountability
- Health Promotion, Prevention and Early Identification
- Access to a Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Health Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce Development

DCF began in 2014 to implement the behavioral health/mental health plan, in partnership with eleven other state agencies, numerous private agencies and children and families of Connecticut. A number of steps remain to be taken in achieving the goals of the plan, ensuring that Connecticut's children and families have full access to quality mental health care in support of achieving social, emotional, and behavioral well-being.

Children's Mental Health Oversight:
The Commissioner of DCF, Joette Katz, and her staff work closely with the Office of the Governor, the Connecticut State Legislature, consumers and family members, advisory groups, advocacy groups, service providers, and state/federal agencies in meeting the mental health needs of children, youth and families. This includes ongoing collaboration with a diverse array of stakeholders around the state to solicit multiple perspectives in identifying unmet needs and priority areas.

DCF staff lead and participate in numerous committees and workgroups focused on a broad range of issues to meet the mental health needs of children, youth and families in Connecticut. These activities include: Promoting family outreach, engagement and retention throughout the period of care; improving the quality of care through early identification and comprehensive assessment; disseminating and sustaining evidence-based practices; addressing the needs of traumatized children, youth and their parents/caregivers; enhancing the knowledge, skills and competencies of the workforce; improving data collection, analysis and reporting systems; integrating plans of care across multiple systems; and enhancing the role of families and other caregivers in all aspects of system design, planning, monitoring and evaluation.

In its oversight role DCF partners with several state advisory committees, boards and service organizations in addressing the mental health needs of children, youth and families. These partnerships include the following.

State Advisory Council (SAC): Mandated by Connecticut statute the State Advisory Council (SAC) is a fifteen-member committee appointed by the Governor to assist DCF by providing input into each of the Department's mandated areas of responsibility, including children's mental health. The primary duties of the Council are to: Review policies; recommend programs, legislation or other matters that will improve services for children, youth and families; review and advise the Commissioner of DCF on the proposed agency budget; perform public outreach to educate the community regarding policies, duties and programs of the Department; and issue any reports it deems necessary to the Governor and the Commissioner. The SAC also assists in the development of, review and comment on the strategic plan for the Department; and it also reviews quarterly status reports on the plan, independently monitors progress and offers an outside perspective to DCF.

Children's Behavioral Health Advisory Committee (CBHAC): Established by Connecticut Public Act 00-188, CBHAC's charge is to promote and enhance the provision of mental health services for all children and youth in the state of Connecticut. The committee supports DCF's efforts in meeting the mental health needs of children, youth and families.

The committee meets at least monthly and evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the Commissioner of DCF on children and families; and it submits biannual "recommendations concerning the provision of mental health services for all children in the state" to DCF, and the legislature. The committee advises on the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. CBHAC members also actively participate in the CT Joint Behavioral Health Block Grant Planning Council.

The committee has four (4) ad hoc sub-committees to address recurring areas of focus which are: (1) expansion of the mental health service array; (2) recruitment, training and retention of family members in various system roles;

(3) educational advocacy and (4) creation of a statewide council, or network, of community collaboratives. The majority of CBHAC members must be “parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child” and appointed members being limited to two two-year terms. CHBAC is chaired by two persons from its membership, at least one of which is a parent of a child with serious emotional disturbance.

Youth Advisory Boards: DCF staff work in partnership with and solicit input from local Youth Advisory Boards around the state and the statewide Youth Advisory Board. The boards empower children and youth to directly participate in and advocate for mental health and related system changes and development. Approximately 50 children and youth in "out-of-home care” participate on the boards. DCF Commissioner Joette Katz has dinner with the state wide Youth Advisory Board on a quarterly basis. In 2015 youth developed and issued the Adolescent Bill of Rights and in January 2017 created a document entitled Adolescent Needs Prior to Transitioning from Care, to ensure that every youth who exits out of the foster care system has the opportunities, resources and supports necessary to achieve a stable transition into adulthood.

Connecticut Community Non Profit Alliance (The Alliance): This member based association represents Connecticut organizations that provide services for children, adults and families in the areas of mental health, substance use disorders, developmental disabilities, child and family health and well-being, and other related areas. The association’s mission is to achieve service system change, represent the voices of its members at local, state and federal levels, and support the delivery of high quality, efficient and effective services. Member organizations deliver services to around 500,000 Connecticut residents each year. The Alliance collaborates with DCF in addressing the mental health needs of Connecticut’s children, youth and families.

State Agency Collaborations

The Commissioners from DCF and the Department of Mental Health and Addiction Services (DMHAS), Department of Developmental Services (DDS), the Connecticut Judicial Branch, Court Support Services Division (CSSD), Department of Social Services (DSS), Department of Public Health (DPH), State Department of Education (SDE) and others meet and dialogue routinely and share in a number of joint activities, Memorandum of Understanding (MOUs) and shared projects regarding cross-cutting

mental health issues of importance to each of the agencies. Some of these activities, MOUs and projects with DCF include the following:

1. Alcohol and Drug Policy Council (DMHAS)
2. Transitioning Young Adults (DMHAS)
3. CT Strong (DMHAS)
4. Project Safe (DMHAS)
5. Project Safe RSVP, (DMHAS) - a family court diversion program.
6. Joint State Behavioral Health Planning Council (DMHAS)-to develop and evaluate the Block Grant Application and Plan as well as the Implementation Report each year
7. Management of Public Health Behavioral Health System for Medicaid Recipients (DMHAS, DSS)
8. Birth to Three Services (DDS)
9. Policy improvements and transportation issues related to foster children (SDE)
10. The shared dissemination of evidence-based practices such as Multi-Systemic Therapy and Multi-Dimensional Family Therapy (CSSD)
11. Adolescent Community Reinforcement Approach (CSSD)
12. School Based Diversion Initiative (CSSD)
13. IMPACCT (CSSD)
14. FBR evaluation (UCONN Health Center)
15. Supportive Housing and Homelessness (DOH)
16. Elm City Project Launch (DPH)

Administrative Service Organization Partnership

In its mental health oversight role, DCF is a partner of the Connecticut Behavioral Health Partnership (CT-BHP), the state's administrative service organization (ASO) focused on a number of initiatives and activities addressing the mental health needs of children, youth and families. This includes a joint requirement for Enhanced Care Clinics (ECC) to develop and implement MOUs with pediatric primary care providers such as pediatricians. The ECC's are specially designated Connecticut based mental health and substance use clinics that serve children and/or adults. They provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other special services for CT-BHP members.

Since the pediatric primary care providers often have first contact with children and youth with mental health service needs the CT-BHP and DCF have worked to forge relationships between pediatric primary care and behavioral health providers through

the Enhanced Care Clinics. The MOU's with pediatric primary care providers are designed to improve care coordination through the phases of referral, treatment and discharge planning. A "train the trainer" program has been developed and disseminated for use by ECC staff to assist pediatric primary care providers to increase opportunities for collaborative care. The training includes a toolkit with in-service training modules. The Symptom Checklist is also promoted as a tool for use in primary care settings to promote integrated care.

Licensing Mental Health and Related Services

As part of its ongoing responsibilities in overseeing mental health services for children, youth and families in Connecticut, DCF licenses a number mental health and related services for children, youth and families, including child placing agencies, outpatient psychiatric clinics for children, extended day treatment programs; short-term assessment and respite programs, short-term family integrated treatment programs, therapeutic foster care, therapeutic group homes and residential treatment programs.

Credentialing Mental Health and Related Services

DCF oversees a number of community based mental health services to meet the individual needs of children, youth and families through a credentialing system. DCF has contracted with Advanced Behavioral Health, a Connecticut service organization, to administer a system for credentialing individuals and organizations that provide direct mental health and related services to children, youth and families. These services are funded by DCF, are available to DCF involved families, are provided in the community and include: After school clinical support services for children and youth, assessment services including assessments for perpetrators of domestic violence, behavior management services, supervised visitation services, and temporary care services. The credentialing process includes:

- Reviewing background information that is submitted with the individual's application including criminal records, child protective service registry and sex offender registry
- Reviewing the Federal Office of the Inspector General's website registry of professional healthcare providers and entities excluded from participation in federal healthcare programs
- Receiving and recording complaints regarding provider service quality and performance
- Conducting quality site visits for all After School programs to assure the program is offered in a safe and secure setting

Mental Health Services Oversight

For all community based and congregate care mental health services that are contracted, credentialed, licensed and provided by DCF for children, youth and families there are specific ongoing activities that are conducted to ensure effectives services and outcomes. In addition to staff dedicated to licensed and credentialed programs DCF has dedicated staff to oversee the department's contracted mental health programs and services. These staff are called "Program Development and Oversight Coordinators" (PDOC). The mental health services oversight conducted by assigned DCF staff include: site visits; qualitative reviews; provider meetings, data discussions, (including data on consumer satisfaction); quality improvement plans; remediation activities and other continuous quality improvement activities.

Description of the State Mental Health Service System for Children:

The Connecticut Department of Children and Families mental health service system is based on the core values and principles of the System of Care: ***"all treatment, support and care services are provided in a context that meets the child's psychosocial, developmental, educational, treatment, and care needs. The treatment environment must be safe, nurturing, consistent, supervised, and structured."***

The DCF Practice Standards for the System of Care Community Collaboratives affirms that all children's mental health services should be:

- Child-centered, family-focused with the needs of the child and family dictating the types and mix of services provided
- Community-based/least restrictive with the focus of services as well as the management and decision-making resting at the community level
- Cultural and linguistically competent, with agencies, programs and services that are responsive to the cultural, racial, ethnic and linguistic differences of the populations they serve

The intended outcomes of the DCF "Strengthening Families Practice Model" include the following:

- Prevention-fewer families need DCF Services
- Children remain safely at home, whenever possible and appropriate
- Children who come into DCF care achieve more timely permanency
- Improved child well-being; all children in our care and custody are healthy, safe and learning; that they are successful in and out of school, and that we help

them find and advance their special talents and to give something back to their communities

- Youth who transition from DCF are better prepared for adulthood

Cultural and Linguistic Competence

Another core principle for DCF is that all children and families are affirmed and valued for their unique identities and qualities. The agency believes in the inclusion of diverse experiences from all people. As such, there is acknowledgement of the injustices made by our dominant society whereby racism has permeated through many of our social systems. This has led DCF towards becoming a racially just organization. All DCF policies, practices, initiatives and services are aligned with these principles. This assures that the diverse needs of children and their families, regardless of their race, religion, color, national origin, gender, disability, sexual orientation, gender identity or expression, age, social- economic status, or language are met. The DCF Division of Multicultural Affairs is charged with developing, implementing, and sustaining diversity initiatives and policies designed to meet these needs. DCF has been focused on the issue of racial justice for many years. Its formal journey began in 2005 as a participant in the national Breakthrough Series Collaborative focused on disproportionality and disparities sponsored by Casey Family Programs. After a series of leadership and organizational changes, the Department renewed its focus on these issues in 2011 by bringing in the People's Institute for Survival and Beyond. This resulted in two external consultants (Heidi Brooks and Jen Agosti) being contracted in February 2012. This facilitation continues with both statewide and regional specific support.

The shifts in racial, ethnic, linguistic, religious, special needs, disability, and gender orientation diversity in Connecticut have required that the Department develop approaches and skills that will enable its staff and all service providers to effectively work with people from diverse backgrounds. Training initiatives and case practices for DCF staff are focused on: cultural awareness, knowledge acquisition and skills development. Cultural awareness includes a process of self-exploration that results in a clear understanding of the worldview that directs interactions with children and families who are different than the staff providing services for them. Knowledge acquisition, includes an expectation that staff are to be thoroughly familiar with the language of multiculturalism and culturally competent practices. Skills development includes trainings focused on what are, and how to apply multi-culturally competent practices, and ongoing self-assessments

All DCF contracts with service providers require the delivery of culturally competent services and supports. Quality assurance mechanisms are in place to review and assure the delivery of culturally competent services by providers. The following is an example of DCF contract language:

"The Contractor shall administer, manage and deliver a culturally responsive and competent program. This shall, at a minimum, be evidenced by equity and parity in access to services, consumer satisfaction, and outcomes for clients served, regardless of race, ethnicity, language, religion, gender, sexual orientation, economic status and/or disability. Policies, practices and quality improvement activities shall be informed by the needs and demographics of the community served or to be served by the program. The Contractor shall include access, consumer satisfaction and outcomes as elements of its program review and monitoring."

"The Contractor shall recruit, hire and retain a professional and paraprofessional staff that is culturally and linguistically diverse. Staff development to support cross-cultural competency shall occur both pre- and in-service. Furthermore, as a means to facilitate culturally competent service delivery, issues of diversity and multiculturalism shall be included in treatment/service planning, discharge planning, case reviews, grand rounds, analysis and review of program data, and staff supervision."

As part of the Connecticut Network of Care Transformation (CONNECT) SAMHSA System of Care grant, a workgroup was developed to plan and implement a statewide process for incorporating enhanced Culturally Linguistically Appropriate Services (CLAS) standards within the children's Network of Care in Connecticut. With a goal to partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.

The outcomes and results were that cohorts were formed to participate in *Connecting with CLAS*. Additionally, state and agency partners support, the recruitment efforts of the *Connecting with CLAS Team.* Two Cohorts of twelve agencies each completed their *Health Equity Plans*. Technical Assistance was provided to review their progress, support their efforts, and receive guidance or recommendations for next steps. This included: two site visits per agency, four large group meetings (all cohort agency workgroups coming together), and eight technical assistance conference calls. Currently recruitment is occurring for 42 organizations to participate in Cohort 3.

Consistent with its diversity principles and practice DCF has implemented the Safe Harbor Project which has the following mission statement: ***"The Safe Harbor Project***

seeks to ensure the safety, support and nurturance of all children and youth, regardless of their race, inherent sexuality, gender identity or expression by ensuring culturally competent, unbiased and affirming service by all DCF staff and its contracted providers."

The Safe Harbors Project is supported and implemented by having specialized liaisons in all DCF regional service offices and DCF operated facilities. The Safe Harbors Project liaisons are subject matter experts in the area of culturally competent and relevant service delivery for children, youth and families who identify as gay, lesbian, bisexual, transgender, intersex and those questioning their sexuality and gender identify. There is a Safe Harbors Project website which contains relevant information and resources for children, youth, families, DCF staff and service providers.

Access to Services:
Children and youth with serious emotional disturbance and their families often find themselves in need of services and/or supports that they are unable to afford and for which there is no other method of payment. To address this service access need DCF has implemented a program of flexible funding for non-DCF involved children, youth and their families involved in care coordination.

The target population for DCF's Care Coordination and flexible funding of services is children or youth with serious emotional disturbance who are at risk of out-of-home placement, have limited resources or have exhausted resources including commercial insurance, have complex needs that require multi-agency involvement; and have no formal involvement with child welfare or juvenile justice.

The DCF flexible funding:

- Supports the wraparound child and family team meeting process and are tied to an objective in a child's Individualized Plan of Care. These may include a variety of non-traditional and unique services, supports or care.
- Supports families with children who have significant behavioral health needs. Assists the child and family in achieving the therapeutic goals outlined in the Plan of Care (POC).
- Helps children remain in their home and community; and achieve the highest level of functioning and life satisfaction possible as its ultimate goal.
- Must be the payer of last resort. In the case of funding for clinical services that would otherwise be reimbursed by third parties - Medicaid, private insurance, etc.

Diverse Mental Health Service Array:
A wide range of over ninety clinical and non-traditional services, programs and rehabilitative supports are available across the state, including services to address trauma and co-occurring disorders. (Please refer to the Connecticut Service Array on pages 18-39 for details of DCF services.)

The continuum of services provided by DCF is characterized by: Data driven planning and decision making; a balance of promotion, prevention, early intervention and treatment services; attention to the child's development and the developmental appropriateness of interactions and interventions; and collaboration across a broad range of formal and informal systems and sectors to develop comprehensive strategies and effective mental health services.
DCF, in partnership with the Connecticut Child Health and Development Institute, service providers and academic institutions has disseminated a range of evidence-based and best practice mental health service models. These community based service models result in improved service outcomes for children, youth and families. They include

1. **Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC)**
2. **Care Coordination (using the evidence based wraparound process)**
3. **Child and Family Traumatic Stress Intervention (CFTSI)**
4. **Cognitive Behavioral Intervention for Trauma in Schools and Bounce Back (CBITS/BB)**
5. **Early Childhood Services - Child FIRST**
6. **Functional Family Therapy (FFT)**
7. **Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)**
8. **Multidimensional Family Therapy (MDFT)**
9. **Multi-systemic Therapy (MST)**
10. **Multi-systemic Therapy - Building Stronger Families**
11. **Multi-systemic Therapy - Family Integrated Transitions (MST-FIT)**
12. **Multi-systemic Therapy - Problem Sexual Behavior**
13. **Multi-systemic Therapy – Transitional Age Youth (MST-TAY)**
14. **Parenting Support Services and Circle of Security (Triple P)**
15. **Recovery Specialist Voluntary Program. Recovery Case Management Services (RSVP-RCM)**
16. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

17. Therapeutic Child Care
18. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
19. Wrap Around New Haven (Care Coordination)

(For a full description of the Evidence Based Practices (EBPs) see pages 33-36)
Reflecting the diverse array and full range of mental health services provided to children, youth and families, DCF also operates two mental health facilities in the state. The Albert J. Solnit Center North Campus is a Psychiatric Residential Treatment Facility (PRTF) serving adolescent males with serious emotional disturbances. The Albert J. Solnit Center South Campus has both in-patient psychiatric units and PRTF units serving child and adolescent females and males with serious emotional disturbances. Both facilities are funded by DCF and serve all children and youth across Connecticut.

DCF has worked to ensure that its mental health services meet the emerging needs of children, youth and families and are consistent with current clinical research and practice. The department's work specifically in the area of human trafficking and trauma informed care is highlighted below as an example.

Human Anti-Trafficking Response Team (HART): The State of Connecticut has taken a number of steps to identify and respond to victims of human trafficking, and DCF has taken a lead role in addressing the human trafficking of children and youth. The Human Anti-trafficking Response Team (HART) was created in order to focus on and reduce the commercial sexual exploitation of children (CSEC) and Domestic Minor Sex Trafficking (DMST).

The Connecticut State Legislature has created several pieces of legislation between 2010 and 2017 to promote public awareness and prevention of child sex trafficking, to provide for ongoing monitoring of efforts to combat trafficking, to clarify mandatory reporting, and to provide a statewide oversight and monitoring body. Consistent with legislative mandates DCF has increasingly sharpened its focus on the growing issue of DMST and CSEC afflicting children across the State. Since 2008, over 605 children have been referred to DCF as possible victims of DMST/CSEC. DCF has put forth efforts to end the trafficking of our children and youth. These efforts fall within three categories: 1) Identification and Response; 2) Awareness and Education; 3) Restoration and Recovery

There are six HART Teams in Connecticut. These are inter-disciplinary teams lead by experienced HART liaisons and include; the child's treatment team, specialized providers

and legal representation if indicated. The HART liaisons work with the local multi-disciplinary Team ensuring that the victims are afforded all the resources needed to maximize prosecutions while ensuring the youth and their families are provided the appropriate mental health and medical services required.

Organizational Structure – Community Level

As the result of a SAMHSA CONNECT federal System of Care grant and recent Connecticut legislation DCF is providing leadership at the regional and local level to more formally operationalize and develop local and regional behavioral networks of care. Traditionally, DCF used its contracted provider network to distinguish its system of care, but feedback from stakeholders and families guided the Department to be more inclusive of all cross child-serving sectors and informal, smaller grass-roots and faith-based organizations. This also includes a focus on better integration of primary care and behavioral health, better connections and relationships between school districts and the behavioral health system, and the development of more access to a broader array of services for all children, youth and families in the state.

Community Based Services versus Congregate Care Services

In 2011, DCF began the process of instituting a number of practice changes to ensure that children and youth with mental health and related service needs grow up in families and receive their services in the community. This meant increasing the state's capacity to serve children and youth in families and the community and reducing the use of more restrictive and costly congregate care.

Historically, Connecticut had one of the highest rates of children and youth placed in congregate care in the nation. For example, in December 2010, DCF had 367 children and youth placed in congregate care settings outside of the state, and in years prior to 2010 there were times when there were more than 500 children and youth placed outside of the state. During this same period, the number of children and youth placed in congregate care settings within Connecticut were at an all-time high. Additionally, use of foster and relative families was well below the national average.

During the period of high congregate care rates, the department's mental health expenditures were disproportionately spent on children and youth in congregate care settings rather than on evidence based, timely and flexible family and community based services that intervene early, promote development and resilience, and provide timely community treatment services in support of maintaining children and youth in families.

In 2011, DCF obtained consultation from the Annie E. Casey Foundation as one of the steps in developing and implementing the changes needed to ensure that more children and youth grow up families. The consultation partnership assisted DCF in the areas of the more effective use `congregate care placements and shifting those funds saved to develop community based services in support of improving permanence and other long-term outcomes for children and youth.

DCF has continued to amplify its work on having children and youth reside in biological, relative and foster families, rather than in congregate care. This work has included the implementation of policy and practice changes that divert children 12 and under from congregate care placements; that reduce the overall use of congregate care; that reduce the length of stay when congregate care is utilized; and implements a system of performance management. In parallel, DCF's behavioral health program development has focused on the repurposing of existing congregate care resources to develop and foster community based care and interventions.
From January 2011 to June 2017:

- The Department has experienced a 6.5% reduction in children in placement
- The percentage of children in Congregate Care decreased 64.6%. The number of children in congregate care is 11.3% of youth in state care.
- The percent of youth in state care who live with a relative or kin has increased from 21% to 40.6%.

With regards to the number of children and youth placed outside of Connecticut in congregate care programs, as of June 1st 2017 DCF had 4 youth placed outside the state, compared to the 367 children and youth placed outside the state in December 2010.

Connecticut Children's Behavioral Health Service Array

DCF Community Based Services for Children, Youth and Families

Prevention & Early Identification/Intervention Services

Care Management Entity (CME) - CME serves children and youth, ages 10-18, with serious behavioral or mental health needs returning to their home or community from congregate care or other restrictive treatment settings (emergency departments/in-patient hospitals, residential treatment, etc.) or who are at risk of removal from home or their community. The CME provides direct services and administrative functions. At the direct service level, the CME employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence-based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the administrative level,

the CME assists DCF in developing local and regional networks of care, which includes the CONNECT federal System of Care grant activities.

Caregiver Support Team - This service seeks to prevent the disruption of foster placements and increases stability and permanency by providing timely in-home interventions involving the child (ages 0-18) and their caregiver/family. For kinship families, this intensive in-home service is provided at the time the child is first placed with the family. The service is available at critical points for the duration of the placement as additional supports are deemed necessary.

Case Management and Recovery Support Programs – This service provides intensive recovery support services and case management, and can include random observed alcohol and drug screenings for parents and caregivers with a substance use problem by facilitating treatment and increasing recovery.

Child Abuse Pediatricians (CAP) – This service provides support and consultation regarding child safety, child abuse and neglect identification/confirmation, and safety planning and decision making. The CAP contractor also reviews a subset of non-accepted DCF reports for infants under 12 months of age who are the highest risk group. Additionally, the CAP contractor delivers education to Area Office and Careline staff regarding abuse and neglect prevention, early identification, recognition, and intervention.

Child First Consultation and Evaluation - This service provides home-based assessment and parent-child therapeutic interventions for high-risk families with children under six (6) years of age and ensures fidelity to the Child First model. The service delivers training, provides reflective clinical consultation, analyzes data, provides technical assistance, insures continuous quality improvement, and certifies sites maintain the Child First model standards.

Community Support for Families - This service engages families who have received a Family Assessment Response from DCF and helps connect them to concrete, traditional and non-traditional supports and services in their community. This collaborative approach and partnership, places the family in the lead role of its own service delivery. The provider assists the family in developing solutions, identifying community resources and supports, and promotes permanent connections for the family with an array of supports and resources within their community.

Connecticut ACCESS Mental Health - This is a consultative pediatric psychiatry service available to all pediatric and family physician primary care provider practices (“PCPPs”) treating children and youth, under 19 years of age irrespective of insurance coverage. The primary goal of the service is improve access to treatment for children with behavioral health or psychiatric problems, and to promote productive, ongoing relationships between primary care and child psychiatry increasing the access to a

scarce resource of child psychiatry. The program is designed to increase the competencies of PCPPs to identify and treat behavioral health disorders in children and adolescents and to increase their knowledge/awareness of local resources designed to serve the needs of children and youth with these disorders.

DCF-Head Start Partnership - All DCF Offices providing services to children, youth and families have established and strengthened a working partnership with Head Start and Early Head Start programs. The goal of the partnership is to ensure children's access to high-quality early care and education, enhancing stability and supports for young children and families, and preventing family disruptions and foster care placements. This supports the prevention of serious emotional disturbance in children and youth and serious mental illness in adults.

Early Childhood Consultation Partnership (ECCP)/Mental Health Consultation to Childcare - The ECCP provides statewide mental health consultation program to pre-schools, Head Start, and service providers funded by DCF. The service is designed to meet the social/emotional needs of children birth to five by offering support, education and consultation to those who care for them. This includes the early identification of young children's social emotional needs and intervention with appropriate services and referrals. The program provides support, education, and consultation to caregivers in order to promote enduring and optimal outcomes for young children. All CT towns and cities have access to this consultation. ECCP is backed by three random control trials contributing to an evidence base for preschool, as well as Infant/toddler Early Childhood Mental Health Consultation (ECMHC) (Gilliam 2007 & 2010).

Elm City Project Launch (ECPL) - ECPL promotes the wellness of young children from birth to 8 years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. ECPL develops, implements and studies the effectiveness of an integrated and collaborative health and mental health service system for children ages 0-8 and their families in New Haven, Connecticut. The program is designed to strengthen and enhance the partnership between physical health and mental health systems at the federal, state and local levels. ECPL uses a public health approach to promote children's health and wellness with efforts that promote prevention, early identification and intervention.

Extended Day Treatment - This service is a site-based, before and/or after school, treatment and support service for children and youth with behavioral health needs who have returned from out-of-home care or are at risk of out-of-community placement due to mental health issues. For an average period of up to six months, a comprehensive array of clinical services supplemented with psychosocial rehabilitation activities are provided to the child/youth and their family/caretaker. A treatment plan is developed cooperatively with the family/caretaker. Transportation is provided by or through the direct service provider or Local Education Authority (LEA). Parents and DCF are full collaborative partners in all aspects discharge planning.

Juvenile Review Board (JRB) - This service creates community-based Juvenile Review Boards, panels composed of community volunteers, who recommend services and supports to be implemented as a diversion from the juvenile justice system, first time misdemeanor or Class D Felony offenders and other qualifying children and youth under the Families with Service Needs (FWSN) statutes. The service allows for the collaboration among community service providers and interested adults, empowering them to take responsibility for the well-being of the youth in their community. Referrals primarily come from schools and local police.

Therapeutic Child Care - This service offers a range of support services for children in a child care facility, including parent-child programs and an after school program. The target population is children ages 0-8. The primary focus is teaching parenting skills to parents as their child is actively involved in a child care setting. By developing a better understanding of child development and skills by the parents, DCF is less likely to become involved and children are less likely to be removed from their family.

Therapeutic Child Care Center(Trauma-Informed) This program is designed to promote, develop, and increase the social, emotional development and cognitive capacities of children, ages 2 years 9 months - 5 years who have been adversely affected by abuse and/or neglect, are presenting with behavioral health issues, and require a therapeutic and trauma-informed program to address these behavioral challenges. The program will be housed within a licensed childcare facility and will also offer support services to parents to increase positive behaviors and promote parent bonding. It is the goal of the Trauma-Informed Therapeutic Child Care Center that children will successfully transition to a less intensive educational setting as a result of the services offered.

Child, Youth and Family Evaluations

Intermediate Evaluation for Juvenile Justice Involved Youth - This service provides a comprehensive and multidisciplinary outpatient assessment and treatment plan development for children and youth involved in the Juvenile Justice System. The primary assessment tool includes full intelligence testing, personality assessment, substance use screening, home visit and family assessment, and evaluation of educational problems and/or learning disability with a report completed within 28 days.

Multidisciplinary Examination (MDE) Clinic - This service provides a comprehensive multidisciplinary evaluation including medical, dental, mental health, developmental, psychosocial and substance use screening for children placed in DCF care for the first time. A comprehensive summary is compiled by the multidisciplinary team and written report provided for each child referred for service. Referral(s) to a specialized service are made as indicated by the findings

Physical and Sexual Abuse Evaluation - This service provides sexual and physical abuse evaluations including a comprehensive and specialized medical examination, psychosocial assessment and a forensic interview of the child in order to determine if abuse has occurred. The evaluation process includes: an initial psychosocial assessment of the family; a physical exam; laboratory work; and a forensic interview of the child, when indicated.

Support Services for Children & Youth, with Mental Health & Related Needs, And Their Families/Caregivers

Adopt A Social Worker - This is a statewide, faith-based outreach program linking an "adopted" DCF Social Worker with a faith-based or "covenant organization" focusing on meeting the basic material needs of DCF-involved families (those with protective service Social Workers as well as foster, adoptive and kinship care families). Meeting the needs of children may include, for example, providing beds, cribs, clothing and household furnishings, will help achieve stabilization of families and permanency for the children.

Be Responsible Be Proud - This service is designed to provide statewide sexual health education for youth involved with the child welfare & juvenile justice system or, to youth who have specialized behavioral, emotional or academic needs.

Community Based Life Skills - The target population served by this program is DCF-committed youth, ages 15 and older, residing in community-based foster homes. The intervention provides youth with a set of skills necessary to assist in their transition from DCF care towards self-sufficiency utilizing a DCF-approved curriculum with experiential learning approaches.

Community Targeted Re-Entry Pilot Program (CTRPP) - This service provides pre-release and post-release support and training for male youth at the Connecticut Juvenile Training School (CJTS), the DCF operated facility for adjudicated youth, including social and life skill building, vocational and career development, psycho-educational programming including character development and leadership interwoven with recreational opportunities provided by the Boys & Girls Club on the campus of CJTS.

Community Transition Program - This service is provided in conjunction with the Norwich Area Office and does assessment and care planning for children/youth who are transitioning from out-of-home levels of care to the community. Services are also provided to keep children/youth who are in the community from being placed in out-of-home care.

Family Support - This service provides coordination and facilitation of five parent support groups focusing on peer support, parenting skill training and support, and education for effective coping strategies. The five groups consist of (1) the CT Chapter of the National Alliance for the Mentally Ill (NAMI-CT), (2) a support group for mothers who have experienced sexual assault in their pre-parenting years, (3) "Parents Night Out" a parent education group, (4) a parent/child play group for parents with children

age birth to three years old that includes an "in-home" education component, and (5) a Gamblers Anonymous support group.

Foster and Adoptive Parent Support Services - This agency-based service supports and trains foster and adoptive parents. Services include but are not limited to: First contact for recruitment through the “Kid-Hero” phone line; a buddy system; post-licensing training; an annual conference; periodic workshops; respite care authorization, a quarterly newsletter as well as a fiduciary role for open adoption legal services. In addition, support staff (“Liaisons”) are situated in most DCF Area Offices in order to assist foster and adoptive families who call with questions or require resolution of individual issues. The Liaisons also assist DCF staff with area recruitment and retention activities for foster and adoptive homes, and serve on committees where a foster/adoptive parent perspective is needed.

Foster Care and Adoptive Family Support Groups - This service provides both a venue and child care support for group meetings for foster care and adoptive families to aid in the retention of foster homes and placement stability for children and youth within foster and adoptive family settings.

Foster Family Support - This service provides a variety of support services to children in DCF care who are living with foster and relative families. The support services include, but are not limited to: Individual, group and/or family counseling; crisis intervention, social skills development, educational activities, and after school and weekend activities.

Foster Parent Support for Medically Complex - This service, staffed primarily by a group of volunteers, provides foster care recruitment, respite and support focused on maintaining and growing the number of foster and adoptive parents who work with medically complex children in the Waterbury and Torrington areas of the state. There is a child care/activity component to the program and money available for participating foster parents as well as two yearly celebrations fostering a peer community for the families.

Fostering Responsibility, Education and Employment (F.R.E.E.) – F.R.E.E. provides reentry support to adolescents and young adults who have been committed to DCF as delinquent and are returning to their community from out-of-home care placement, including public and private congregate care treatment settings, Connecticut Juvenile Training School (CJTS), and youth correctional settings *(*e.g. York, Manson state correctional facilities). Service provision begins in advance of the child’s/youth’s return to the community while in congregate care and continues for a period of time after their return to the community. The service provides an array of services to support the adolescent's growth in all areas of functioning as well as family-focused interventions that build on natural supports, and accessing services and opportunities available in their local service continuum.

Intimate Partner Violence (IPV-FAIR) – The goal of the service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. This four (4) to six (6) month service provides a supportive service array of assessments, interventions and linkages to services to address the needs of families impacted by intimate partner violence. The service will respond to both caregivers and the children. The Fathers for Change Promising Practice Model will also be offered through the IPV-FAIR Service. This service will offer intervention to fathers of children under age 10 who have been an offender of intimate partner violence and have co-occurring substance use issues. Safety planning will be at the center of the IPV-FAIR service provision.

Juvenile Review Board (JRB) - Support and Enhancement - Juvenile Review Board Support and Enhancement provides funding to local Juvenile Review Board's to create, support and enhance services delivered to youth served by the JRB.

Multidisciplinary Team and Child Advocacy Center – This service promotes the coordination of investigations of and interventions for cases of child abuse/neglect among agencies, including DCF, police, medical, mental health, victim advocates, and prosecutors. Cases are referred to the regularly scheduled team meetings by DCF, law enforcement or other agency members of the team. A team Coordinator assumes the coordination and administrative responsibilities in addition to being an active member of the team. Training in aspects of child abuse and the investigation process is provided to the team members. In 2014, state statute changed to include that human trafficking cases must have a MDT response. A Child Advocacy Center(CAC) is a child-focused, facility-based program where professionals from many disciplines, including child protection, law enforcement, prosecution, forensic interviewing, mental health, medical professionals, and victim advocates work together as a team to make coordinated, well-informed decisions about the investigation, treatment, case management and prosecution of child abuse cases. CAC's are designed to meet the unique needs of a community. This is where the forensic interview, and sometimes the medical exam, for a victim will be conducted.

One-on-One Mentoring - This service recruits, trains and supervises individual mentors, who are then matched for a minimum of one year with a male or female youth ages 14 through 21. DCF makes the referrals and provides on-going training and group activities for the mentor/mentee pair. Mentors are screened and trained and, once matched with a youth, receive supervision at least once a month. There is on-going training of mentors and occasional group activities for the mentor/mentee pairs.

Parent Project - This service is a highly structured, 10-16 week parent training program under the nationally recognized trade mark *Parent Project®* and is designed specifically for parents/caregivers of youth/adolescents who engage in risky behaviors such as running away from home, truancy or "pre-delinquent behaviors".

Parent Program (St. Josephs) - This service provides both the General Parenting Program (GPP) and the Dads Are the Difference Program (DAD) for parents involved with DCF. Both programs offer parenting classes and help families connect to needed resources/supports in the community as a means to strengthen families that are at risk of child abuse and neglect by providing parenting education and support.

Parent & Youth Training and Support - The Parent and Youth Training and Support program will deliver training and support to primary caregivers of children with behavioral health and other special needs and to youth with disabilities or those returning from juvenile justice programs or facilities funded by DCF.

Parenting Class - This service provides parenting education and skill building in English, Spanish and or Portuguese to parents in the Greater Danbury area of the state.

Permanency Placement Services Program (PPSP) - This is a permanency placement program dedicated to DCF-committed children to support placement through adoption or guardianship. Services include: Completion of documents to legally free a child for adoption through juvenile court; recruitment, screening, home studies and evaluations; pre- and post-adoption, guardianship placement planning and finalization services or reunification services with biological parents. A written service agreement, mutually developed between DCF and the provider, is made prior to the commencement of services, and includes the type(s) of service(s) to be provided and time to be spent on each service.

Prison Transportation – This service provides bi-weekly transportation for children and youth so they can visit their mothers or guardians who are in prison at York Correctional Institution for Woman. Children/youth in DCF custody are given priority. The service includes toys, books and other forms of entertainment for children to use during travel time. Social work support is available for children who experience emotional difficulty on the way to, during and/or returning from the visits with their mother or guardians.

Respite Care Services - This service provides brief and temporary home and community-based care for children and youth, receiving care coordination who have serious emotional disturbance (SED). This service is offered to families in order to provide relief from the continued care of a child or youth's complex behavioral health care needs, to limit stress in the home environment and to prevent family disruption and/or the need for out-of-home care for a child or youth with SED and is part of an integrated behavioral health care plan. Up to 45 hours of respite can be given to a family within a 12 week period with any extension based upon DCF approval.

Reunification and Therapeutic Family Time – Reunification Readiness Assessment, Reunification Services, and Therapeutic Family Time are designed for families with children (from birth to age 17) who were removed from their home due to protective

service concerns. These three service types are available to families as three separate components based on the needs of the family. Families can be referred for this service immediately following a child's removal from the home or at any time during their placement.

Reunification Readiness Assessment uses a standardized assessment tool to develop service plan. Therapeutic Family Time is made available for families and assists the provider in assessment by using the Visit Coaching model. This component provides feedback and recommendations to the Department regarding the family's readiness for reunification

Reunification Services also uses a standardized assessment tool to develop the service plan, delivers a staged reunification model to support families throughout the reunification process, adopts the Wraparound Model design to engage the family and build their networks of support, delivers Therapeutic Family Time component using the Visit Coaching model and offers a Step Down option, if families require additional supports.

Therapeutic Family Time – Uses the Visit Coaching Model, uses the Keys to Interactive Parenting Scale (KIPS), an evidence based tool to effectively measure parent child interaction and parenting behaviors, preserves and restores parent/child attachment and facilitates permanency planning and emphasizes a continuity of relationships.

School-Based Diversion Initiative (SBDI) - Funded by the Connecticut Judicial Branch, DCF and the CT Department of Education, the SBDI model brings training to school staff for recognizing mental health needs, including trauma exposure, and accessing services and supports in the school and the community. SBDI aims to reduce the number of children who are arrested for relatively minor behavioral incidents that can be addressed through in-school discipline and access to mental health services rather than formal processing through the juvenile justice system. Secondarily, SBDI seeks to reduce the number of youth who are expelled or receive out of school suspension when these students can be held accountable while remaining in school.

Sibling Connections Camp - This service is designed to engage, support and reconnect siblings who are placed in out-of-home care by providing a week long overnight camp experience focused on strengthening sibling relationships and creating meaningful childhood memories.

Statewide Family Organization - **FAVOR** - DCF funds FAVOR (not an acronym), an umbrella statewide family advocacy organization that has been created to educate, support and empower families. FAVOR's mission is to provide family-focused, advocacy-based, and culturally sensitive community services that improve outcomes and family wellbeing. The Statewide Family Organization provides three levels of service and support to families who have children with serious behavioral or mental health needs. At the direct service level: Community Family Advocates provide brief and long term support to parents and caregivers using a wraparound Child and Family Team meeting approach and a peer support/assistance framework. At the regional level: Family

System Managers work closely with DCF Regional Offices and the Connecticut Behavioral Health Partnership (CT BHP) to assist them in developing linkages between local community groups and identifying and supporting informal support and service networks for families. At the statewide level: Citizen Review Panels provide feedback to DCF regarding child protection services and provide training and disseminate information to service providers and the public to enhance the ways families can positively impact the child protection and child treatment systems.

Supportive Housing for Families - This service provides subsidized housing and intensive case management services to DCF families statewide whose inadequate housing jeopardizes the safety, permanency, and well-being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: Economic, social, and health. Housing is secured in conjunction with the family and use of a Section VIII voucher from the Department of Social Services (DSS).

START- Youth Homelessness Program This is a street outreach program which provides multiple services for homeless or unstable-housed youth and young adult's ages 16-24. Services include family mediation, kinship services, referrals to host families for youth under age 18, emergency temporary housing for youth between the ages of 18-24 (as resources permit), provision of backpacks with needed personal hygiene items and educational resource materials, continuing education assistance, benefits assistance, life skills development, and referrals for counseling and substance use treatment.

Supportive Work, Education & Transition Program (SWETP) - This service is a community-based, stand-alone, staffed apartment program that serves DCF-committed adolescents ages 16 and older. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills, including but not limited to: Inter-personal awareness, community awareness and engagement, knowledge and management of medical conditions; and maximization of education, vocation and community integration. On-site supervision is provided 24 hours a day, seven days a week. Activities involving resident youth are supervised and managed at a level consistent with the nature of the activity and the individual needs of the involved youth.

Therapeutic Foster Care (Medically Complex) - This service approves, provides specialized training and support services and certifies families to care for children with complex medical needs. The population served is DCF-referred children and youth with complex medical needs ages 0-17. A child with complex medical needs is one who has a diagnosable, enduring, life-threatening condition, a medical condition that has resulted in substantial physical impairments, medically caused impediments to the performance of daily, age-appropriate activities at home, school or community, and/or a need for medically prescribed services.

Virtual Academy Education Care Management – Virtual Academy Education Care Management – This service is designed to support a portion of the students enrolled in the Department of Children and Families (DCF) Virtual Academy, a USD2 developed and operated online school for juvenile justice and DCF involved children and young adults needing educational remediation, credit recovery, and credit accumulation. Population Served: Students ages 10-21 who have had school failures, absences, and school challenges. Students will also have a diagnosable behavioral health condition that results in moderate to acute functional impairment and limits their ability to function in family, school, or community activities. The referred students may also have had a temporary or long term incarceration or other school interruption.

Work To Learn Youth Program - This youth educational/vocational program provides supportive services to assist youth and young adults, ages 14-23, to successfully transition into adulthood. The program provides training and services in the following areas: Employment skills, financial literacy, life skills, personal and community connections, physical and mental health, and housing. Youth may also take part in an on-site, youth-run businesses providing an additional opportunity to utilize and strengthen their skill set.

Zero to Three – Safe Babies – The Zero to three Safe Babies Project, provides coordination of services to parents and children younger than 36 months in order to speed reunification or facilitate another permanency goal. The children involved in the program have been placed outside of their home for the first time via court order. The service coordination involves facilitating communication and cooperation among a “zero to three team" of stakeholders (e.g. court services, infant mental health, protective services, developmental screening) and the parent(s) to develop and expedite a case specific plan of action toward reunification.

Mental Health Treatment Services

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - CBITS is a skill-based, group intervention focused on decreasing symptoms of Post-Traumatic Stress Disorder (PTSD) and generalized anxiety among children and youth who have experienced trauma. This school-based treatment model enhances the school’s mental health service array to support student’s learning potential and build resiliency. CBITS minimizes developmental disruption and promotes child recovery and resiliency for students through a cognitive-behavioral therapy approach involving components of psycho-education, relaxation, exposure, social problem solving, and cognitive restructuring.

Community Support Team - This service is provided in conjunction with the DCF New Haven Area Office and focuses on assessment, treatment and support for children and youth in out-of-home levels of care transitioning back to the community. Services

include but are not limited to: In home clinical interventions and supports; delivery of therapeutic services that facilitate and support family problem solving; family education and guidance; and linkage to natural supports.

Enhanced Care Clinics (ECC's) - Connecticut established Enhanced Care Clinics (ECC's), which are specially designated mental health and substance use clinics that serve adults and/or children. The ECC's provide routine outpatient services such as individual therapy, group therapy, family therapy, medication management and other routine outpatient services for Medicaid members. The overall goal of the Enhanced Care Clinics initiative is to provide adults and children who are seeking behavioral health services and supports with improved timeliness of access to behavioral health care as well as improved quality of care. ECC's must also be able to meet special requirements starting with access and the ability to see clients in a timely fashion depending on their level of urgency.

Currently under this model, ECC's must adhere to the following access standards: The capability to see clients with emergent needs within two hours of arrival at the clinic, the capability to see clients with urgent needs within two days of initial contact, the capability to see clients with routine needs within two weeks of initial contact. Following an initial face-to-face clinical evaluation those clients who are determined to be clinically appropriate to receive outpatient services must be offered a follow-up appointment within 2 weeks of the initial evaluation. ECC's must also provide extended coverage outside of normal business hours. Evidence of collaboration and coordination with primary care providers around medication management and general medical issues as well as screening, evaluation and treatment of co-occurring mental health and substance use disorders are additional requirement of all ECCs.

Family and Community Ties – This foster care model combines a wraparound approach to service delivery with professional parenting support for children and youth with serious psychiatric and behavioral health problems. This service is differentiated from other foster care services by (a) the frequency and intensity of clinical contact and (b) flexibility in providing "whatever it takes" to preserve the placement of a child or youth in a family setting. Within this program, foster parents serve as full members of the treatment team and complete intensive training in behavior management.

Intensive Family Preservation (IFP) - IFP provides a short-term, intensive, in-home service designed to intervene quickly in order to reduce the risk of out-of-home placement and or abuse and/or neglect. Services are provided to families 24 hours per day, seven days a week with a minimum of 2 home visits per week including a minimum of 5 hours of face to face contact per week for up to 12 weeks. Staff work a flexible schedule, adhering to the needs of the family. A standardized assessment tool is used to develop a treatment plan. If indicated, families are linked to other therapeutic

interventions and assisted with basic housing, education and employment needs including making connections with non-traditional community supports and services.

Intensive In-Home Child and Adolescent Psychiatric Services IICAPS - (Consultation and Evaluation) - This service provides program development, training, consultation, and clinical quality assurance for DCF-approved Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) providers. The IICAPS statewide providers work with children and youth with behavioral health needs who have returned or are returning home from out-of-home care and who require a less intensive level of treatment, or are at imminent risk of placement due to mental health issues or emotional disturbances.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) - This service is a curriculum-based treatment model for children and adolescents with a DSM-V Axis I diagnosis who have complex behavioral health needs. The primary goal is to divert children and adolescents from psychiatric hospitalizations or to support discharge from inpatient levels of care. This intensive, home-based service is designed to address a child's specific psychiatric disorders while remediating problematic parenting practices and/or addressing other family challenges that effect the child and family's ability to function. This service offers five levels of intervention, from as little as 1-3 hours per week to as much as 12-20 hours per week as indicated.

Juvenile Sexual Treatment (JOTLAB) - Juveniles Opting for Treatment to Learn Appropriate Behavior is a comprehensive community-based rehabilitative, specialized extended day treatment program that serves adjudicated and non-adjudicated male and female youth ages 8-17, who have engaged in inappropriate and abusive sexual behaviors. Services include: A comprehensive clinical evaluation, bi-weekly individual psychotherapy, monthly family/caretaker counseling, twice weekly psycho-educational therapy groups as well as twice weekly social skill building groups.

Multidimensional Family Therapy (MDFT) - This service provides intensive home-based clinical interventions for children ages 11-18 exhibiting significant behavioral health issues and who are at imminent risk of removal from their home or are returning home from a residential level of care. After a comprehensive evaluation, a strength-based individualized service plan is developed to include goals, interventions, services and supports that specifically address any issues threatening the maintenance of the child in the home or the return of the child to the home. Staff work a flexible schedule, adhering to the needs of the family. Average length of service is 3-5 months per family.

Multidimensional Family Therapy (MDFT) Consultation and Evaluation - This service provides program development, training, clinical and programmatic consultation to MDFT providers statewide which integrate the standards and practices consistent with MDFT requirements and quality improvement programming. Additionally, this service provides program development, training and clinical consultation for the Family

Substance use Treatment Services (FSATS) teams serving youth who are criminally involved. .

Multi-systemic Therapy: Consultation and Evaluation - This service provides for clinical consultation to state-wide Court Support Services Division (CSSD) and DCF funded Multi-systemic Therapy (MST) providers in order to integrate the standards and practices consistent with MST Network Partnership requirements and MST quality improvement programming. In addition, the service provides training in the theory and application of MST for clinicians, supervisors, administrators, policy makers employed by DCF, CSSD and their contracted MST providers.

Multi-systemic Therapy for Transition-Aged Youth - This service provides intensive individual and community-based treatment to transition-aged youth with both antisocial behaviors and serious mental health conditions. The primary goals of the intervention are to reduce antisocial behaviors and recidivism, treat the mental health condition, and treat existing substance use disorders. Secondary goals are to encourage vocational engagement (schooling, training or working); improve social relationships; support community-based housing; and improve client parenting skills as indicated.

New Haven Trauma Coalition - The New Haven Trauma Network is a collaboration headed by the Clifford Beers Clinic which has four components: (1) Care Coordination; (2) short-term assessment; (3) screening and direct service for children; and (4) trauma informed training & workforce development. These components provide a trauma-informed collaborative network of care to address adverse childhood experiences. The network involves the Greater New Haven community and is focused on: a) Creating a safer, healthier community for children and families; b) reducing community violence; c) reducing school failure and dropout rates; d) reducing incarceration rates; e) improving overall health of children and families; and, f) development of a coalition or network infrastructure support.

Outpatient Psychiatric Clinic for Children (aka Child Guidance Clinic) - This service provides a range of outpatient mental health services for children, youth and their families. Services are designed to promote mental health and improve functioning in children, youth and families and to decrease the prevalence of and incidence of mental illness, emotional disturbance and social dysfunction. DCF-involved children; referred through local systems of care, care coordinators, and Emergency Mobile Services; children who are the victims of trauma and/or physical and/or sexual abuse and/or neglect and/or witness to violence in the home or external to the home and/or who have experienced multiple separations from loved ones; children who are at risk of psychiatric hospitalization or placement into residential treatment; children being discharged from psychiatric hospitals or residential treatment; children with severe emotional disturbances such as conduct disorders and oppositional defiant disorders; children with significant, persistent psychiatric conditions; children who are court involved; children whose families are financially unable to obtain mental health services

elsewhere in the community; children experiencing Reactive Attachment Disorders; children who experience Post Traumatic Stress Disorder; children who exhibit sexually reactive behaviors and children who exhibit sexually predatory behavior.
DCF referrals receive priority consideration. The severity of each referral determines whether an appointment be given that same day, within 3 business days, within 14 calendar days or within 30 calendar days.

Therapeutic Foster Care - This service is an intensive, structured, clinical level of care provided to children with serious emotional disturbance (SED) within a safe and nurturing family environment. Children in a TFC placement receive daily care, guidance, and modeling from specialized, highly-trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing and/or ameliorating a child's mental/behavioral health issues, and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan, and facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or guardianship).

Substance Use Treatment Services

Case Management and Recovery Support Programs – This service provides intensive recovery support services and case management, and can include random observed alcohol and drug screenings for parents and caregivers with a substance use problem by facilitating treatment and increasing recovery.

Family Based Recovery - This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance use. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance use treatment for the parent(s) and attachment-based parent-child therapy.

Project SAFE - This is a statewide program that provides priority access to substance use evaluations, outreach and engagement and outpatient substance use treatment to parent/caregivers who are involved in an open DCF case. Additional services include assisting families to gain access to mental health, medical, social, educational, vocational, housing and other services essential to meeting basic human needs.

Reentry and Family Treatment (RAFT) This service, Reentry and Family Treatment (RAFT) Program, expands the publicly-funded adolescent substance use treatment system to provide enhanced Multi-Dimensional Family Therapy (MDFT) services to substance-abusing juvenile offenders being released after a year or more in a controlled

environment back to the cities of Hartford, New Britain, Bridgeport, Milford, New Haven, and Waterbury.

Evidence Based Treatment Programs

Adolescent Community Reinforcement Approach/Assertive Continuing Care (ACRA-ACC) - This service is an evidence-based substance use outpatient treatment program for substance-using adolescent's ages 12 through 17 years and their caregivers. The model provides a combination of clinic, community and home-based services, based on the individualized need of the youth and family served.

Care Coordination - This evidence based service provides high fidelity "Wraparound" care through the use of the Child and Family Team process. Wraparound is defined as an intensive, individualized care planning and management process for youths, ages 0-18, with serious or complex need. The primary goal of Care Coordination is to support and maintain youth exhibiting serious emotional and behavioral problems in their home and community. The Wraparound process and the written Plan of Care it develops are designed to be culturally competent, strengths based and organized around family members' own perceptions of their needs, goals, and vision.

Child and Family Traumatic Stress Intervention (CFTSI)
CFTSI focuses on two key risk factors (poor social or familial support, and poor coping skills in the aftermath of potentially traumatic events) with the primary goal of preventing the development of PTSD. CFTSI seeks to reduce these risks in two ways: (1) by increasing communication between the affected child and his caregivers about feelings, symptoms, and behaviors, with the aim of increasing the caregivers' support of the child; and (2) by teaching specific behavioral skills to both the caregiver and the child to enhance their ability to cope with traumatic stress reactions

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - The evidence based Cognitive Behavioral Intervention for Trauma in Schools program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters.

Early Childhood Services - Child FIRST - This evidence based service provides home based assessment, family plan development, parenting education, parent-child therapeutic interventions, and care coordination/case management for high-risk families with children under six years of age in order to decrease social-emotional and behavioral problems, developmental and learning problems, and abuse and neglect.

Child First is an evidenced based model of treatment with strict fidelity to the Child First model.

Early Serious Mental Illness ESMI-ICM– This service will provide early identification of FEP, rapid referral to evidence-based and appropriate services, and effective engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders.

Functional Family Therapy (FFT) – FFT is an evidenced-based practice providing an intensive period of clinical intervention, family support and empowerment, access to medication evaluation and management, crisis intervention and case management in order to stabilize children at risk of out-of-home placement due to mental health issues, emotional disturbance or substance use, or to assist in their successful return home from an alternative level of care. Twenty-five percent (25%) of the services are provided to youth involved with DCF Juvenile Service - Parole. Length of service averages approximately 4 months. The tenets of the FFT model provide for flexible, strength-based interventions and are offered primarily in the client's home as well as in community agencies, schools and other settings natural to the family.

Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) – This is an evidence-based treatment designed for children ages 7 - 15. Unlike most treatment approaches that focus on single disorders, MATCH is designed for multiple disorders and problems, including anxiety, depression and posttraumatic stress, as well as disruptive conduct such as the problems associated with ADHD (Attention Deficit Hyperactivity Disorder).

Multidimensional Family Therapy (MDFT) – This is an evidence based comprehensive and multisystemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance use and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance use and related problems.

Multi-systemic Therapy (MST) - This service, using a national evidence-based treatment model, provides intensive home-based services to children who are returning or have returned from a residential level of care or are at imminent risk of removal due to mental health issues. Following a comprehensive evaluation, a strength-based individualized service plan is developed to include goals, interventions, services and supports that address the issues and problems threatening the maintenance of the child in the home or the return of the child to the home. This service promotes change in the natural environments such as the home, school and community. Interventions with

families promote the parent's capacity to monitor and intervene positively with their child and/or youth. The clinical supervisor and therapists have daily contact with each family served including providing 24 hour a day, 7 day a week access. Average length of service is 3-5 months per family.

Multi-systemic Therapy - Building Stronger Families - Using a national evidence-based treatment model, intensive family and community based treatment is provided to families that are active DCF cases due to the physical abuse and/or neglect of a child in the family and abuse of or dependence upon marijuana and/or cocaine by at least one caregiver in the family. Core services include: Clinical services, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 8 months per family.

Multi-systemic Therapy - Family Integrated Transitions (MST-FIT) – MST-FIT uses the evidence-based Intensive Home Based (IHB) treatment model to provide integrated individual and family services to children/adolescents with co-occurring mental health and chemical dependency disorders upon their re-entry back into their communities from a residential or juvenile justice facility back into their communities. MST-FIT promotes behavioral change in the natural environment including helping parents learn to monitor and to intervene positively with their children/adolescents.

Multi-systemic Therapy - Problem Sexual Behavior - This service provides clinical interventions for youth who are returning home from the Connecticut Juvenile Training School (CJTS) or a residential treatment program after having been identified as being sexually abusive, sexually reactive and/or sexually aggressive behaviors. The youth have been identified as needing sexual offender specific treatment. The service is based upon an augmentation of the standard MST team model, an evidence based clinical model with an established curriculum, training component and philosophy of delivering care. The average length of service is 6-8 months per youth/family. All clients referred receive a comprehensive evaluation resulting in a multi-axial diagnosis and individualized treatment plan.

Multisystemic Therapy – Transitional Age Youth (MST-TAY) – This is a promising evidenced based model that provides intensive individual treatment for transitional age youth (ages 17-20) with both a recent history of criminal involvement and mental health challenges. The goal of MST-TAY treatment is to stabilize youth with significant mental health impairments and other high risk behaviors within the community through intensive multi-weekly treatment sessions for up to six months. The clinical focus is on safety preservation, crisis management, establishing natural supports and increasing life skills to support the youth's transition into adulthood. Immediate social and family resources are also integrated into treatment to promote a healthy natural social support network for the client and to sustain treatment advances. Youth are treated as part of an interdisciplinary team and are assigned a life coach to work with the identified client

on supplemental life skills, vocational, educational, and social reinforcement needs throughout treatment and for an additional 6 months of aftercare.

Parenting Support Services (previously known as Triple P) -This service is for families with children 0-18 years-of-age to support and enhance positive family functioning. Families receive one or more of the PSS interventions along with case management services using the Wraparound philosophy and process. PSS offers the evidenced-based model, Level 4 Triple P (Positive Parenting Program®) and the Circle of Security Parenting© intervention. Triple P helps parents become resourceful problem solvers and be able to create a positive and safe home learning environment for children to develop emotional, behavioral, and cognitive strengths. Circle of Security Parenting (COS) is designed to build, support, and strengthen parents' relationship capabilities so they are better equipped to provide a quality of relationship that is more supportive of secure attachment.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) - This is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - Trauma-Focused Cognitive Behavioral Therapy is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.

Wrap Around New Haven – Funded by a CMS Innovative Health Grant this initiative delivers evidence-based, culturally-appropriate, integrated medical, behavioral health, and community-based services coordinated by a multidisciplinary Wraparound Team. The Team collaboratively identifies high-need families in New Haven with complex medical and behavioral health care needs, integrates services across multiple health care institutions (e.g., hospital, community health clinic, mental health clinic, and two school based health clinics) reducing care fragmentation that places families at risk for poor care, poor outcomes, and excessive health care costs.

Crisis Services

EMPS – Mobile Crisis Services - EMPS is a mobile crisis intervention for children experiencing behavioral health or psychiatric emergencies. The service is delivered through a face-to-face mobile response to the child's home, school or other location preferred by the family. In rare situations the intervention can be delivered telephonically, or in rare situations through a telephonic intervention, if appropriate.

EMPS - Crisis Intervention Service System - Statewide Call Center – The Statewide Call Center is the entry point for access mobile crisis services for all children and youth in Connecticut. The Statewide Call Center receives calls, collects relevant information from the caller, determines the appropriate initial response, and links the caller to the information or service indicated. In addition to these primary functions, the Statewide Call Center also collects data regarding calls received, triage responses and referrals to EMPS contractors. The Statewide Call Center operates 24 hours per day, 365 days per year. The Call Center analyzes statewide data and compiles reports for DCF, the Statewide Call Center, EMPS contracted service providers, and other entities as determined by DCF.

Performance Improvement Center - This service supports and sustains the delivery of high quality Emergency Mobile Crisis Services (EMPS) and, Care Coordination throughout the state of Connecticut by directing and implementing quality improvement activities and standardized training to EMPS, and Care Coordination contractors. Quality Improvement activities include the collection, analysis, and reporting of quality improvement data provided by the EMPS Call Center (211) and EMPS contractors (and sub-contractors). Monitoring and supporting EMPS quality is provided by a combination of consultation, satisfaction surveys, fidelity ratings, and other activities. Training and workforce development activities for, Care Coordination and EMPS include the provision of pre-service, in-service and special topic training in the core competencies necessary to operate a quality service.

DCF Congregate Care Services for Children, Youth and Families

Mental Health Treatment Services

Preparing Adolescents for Self-Sufficiency (PASS) - This service is a group home/congregate-care behavioral health treatment setting for youth. A PASS Group Home provides an environment that fosters individualized maximum outcomes in the areas of education, vocation, employability, independent living skills, health and mental health, community connections, and permanent connections.

Short Term Assessment and Respite Home (STAR) – STAR is a temporary congregate care program that provides short-term care, evaluation and a range of clinical and nursing services to children and youth removed from their homes due to abuse, neglect or other environments which are high-risk. Staff provide empathic, professional child-care, and develop and maintain a routine of daily activities similar to a nurturing family structure. The children and youth receive assessment services, significant levels of structure and support, and care coordination related to family reunification, or matching with a foster family or a congregate care setting, as indicated.

Specialized Group Home with Behavioral Health and Support Services - This group home is staffed 24 hour, 7 days a week and is located within the community. It serves multiple

youth and young adults, ages 16 through 21, with serious emotional disturbance and their families through the provision of comprehensive, coordinated care and clinical treatment by specially-trained staff.

Therapeutic Group Home - This service is a small (4-6 bed) staffed home within a local community designed for youth with psychiatric/behavioral issues (must have a specific Axis I diagnosis). Youth entering these homes come primarily from larger residential facilities. Therapeutic techniques/strategies are utilized in the relationship with the child, youth and family, primarily through group and milieu experiences. The service provides an intensive corrective relationship in which therapeutic interactions are dominant, thereby assisting the children and youth in improving relationships at school, work and/or community settings. Appropriate linkages with alternative or transition services are in place prior to a child or youth's discharge.

Substance Use Treatment Services

High Risk Infant Program - This service is a long-term residential substance use treatment program for pregnant and/or parenting women and their children. Licensed by the Connecticut State Department of Public Health this program accommodates eight women and seven children in residence. The model is a structured, drug-free residential environment composed of various components to meet each resident's individual, medical, emotional and specific treatment needs. The parents receive educational and skills training in order to develop skills and implement positive interactions with their children.

Residential Substance use Treatment - Children's Center of Hamden - This service provides brief residential substance use treatment for male and female adolescents, ages 12-17 involved with juvenile or adult court.

Crisis Services

Crisis Stabilization - This service provides short term, residential treatment for children and youth with a rapidly deteriorating psychiatric condition, in order to reduce the risk of harm to self or others and divert children and youth from admission into residential or inpatient care. Interventions focus on stabilization of the child and youth's behavioral health condition including addressing any contributing environmental factors and enhancing existing outpatient services available.

Short-Term Family Integrated Treatment (S-FIT): This is a short-term residential treatment option providing crisis stabilization and assessment, with rapid reintegration and transition back home. The primary goal of the program is to: Stabilize the child, youth and family (adoptive, biological, foster, kin, or relative) and strengthen their extended social system; assess the family's current strengths and needs; identify and mobilize community resources; and, coordinate services to ensure rapid reintegration

into the home. S-FIT is an alternative to psychiatric hospitalizations and/or admissions to higher levels of care, and seeks to stop placement disruptions. The program serves DCF involved children and adolescents ages 12- 17 (with an option to seek a waiver through DCF licensing for children under the age of 12). Many of these children and youth will have experienced multiple disruptions or a particularly traumatic event and have significant mental health and/or medical and high-risk behavior management needs.

DCF Behavioral Health System Strengths

Connecticut's behavioral health system has a number of strengths, but the following eight are noteworthy: First, Connecticut has a strong and robust system with an impressive statewide capacity across a diverse service array. (See above description of CT service array) Second, Connecticut has one of the strongest evidence based service arrays in the nation. (See list and description above) Third, Connecticut has a strong trauma informed care system. (See description below) Fourth, Connecticut has adopted the system of care approach, and as a result we have a large family involvement component and the strength based, family-driven approach is well established (See description below). Fifth, Connecticut strongly promotes prevention health and wellness. Sixth, Connecticut has a strong family-centered child welfare practice model. Seventh, Connecticut has a number of infant and early childhood mental health initiatives. (See below description) Finally, Connecticut has engaged and developed strong partnerships with many stakeholders including the behavioral health community providers, families, schools, pediatric primary care providers, faith-based institutions and small informal grass-roots organizations.

System of Trauma-Informed Care

The Connecticut Department of Children and Families has been building a statewide system of trauma informed care for children, youth and families. This is based on the knowledge that the DCF staff and providers of service must be both trauma-aware and trauma-informed to address the multiple challenges that traumatized children, youth and their families bring with them. Children and youth who are involved with and receive services through DCF have typically experienced or been exposed to traumatic events such as physical abuse, sexual abuse, chronic neglect, sudden or violent loss of or separation from a loved one, domestic violence, and/or community violence. Often these children and youth have emotional, behavioral, social and mental health challenges that require special care and treatment. This has significant implications for the delivery of services. The DCF trauma aware and trauma-informed system seeks to

change the engagement paradigm with children, youth and families from one that asks, "What is wrong with you?" to one that asks, "What has happened to you?"

Trauma-informed care is an overarching framework for DCF, which incorporates trauma awareness and guides general practice with children, youth and families who have been impacted by trauma. Trauma awareness is acknowledging the presence of trauma symptoms in individuals with histories of trauma and understanding the role that trauma has played in their lives. The DCF trauma informed care system promotes healing environments and prevents re-traumatization by embracing "key" trauma-informed principles of safety, trust, collaboration, choice, and empowerment. In addition, the trauma informed care system requires the use of evidence-based trauma specific services and treatments. The trauma-informed approach implemented by DCF incorporates the following basic strategies:

- Maximize the child, youth and family's sense of physical and psychological safety
- Identify the trauma-related needs of children, youth and families
- Enhance the child, youth and family's well-being and resiliency
- Partner with families and system agencies
- Enhance the well-being and resiliency of the DCF workforce
-

DCF has taken a number of steps in building a system of trauma informed care. Beginning in 2007, DCF utilized a combination of DCF state funds, Mental Health Block Grant funds and a federal grant from the Administration for Children and Families to partner with a coordinating center, the Child Health and Development Institute (CHDI) to disseminate Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in community-based children's outpatient clinics across Connecticut. This is an evidence based practice for children and youth ages 4 through 21 and their caregivers who have experienced a significant traumatic event and are experiencing chronic symptoms related to the trauma exposure. TF-CBT is a time limited intervention, which usually lasts five to six months and involves outpatient sessions with both the child and caregiver. There are currently over 35 clinics in Connecticut, over 72 total sites and an additional 88 clinicians were trained this year to bring the total to 888 clinical staff trained to provide TF-CBT.

In 2014 DCF began implementation of the evidence based “Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and/or Conduct Problems” (MATCH) for children, youth and their caregivers. MATCH is a mental health assessment and treatment model designed to deal with multiple problems and disorders encompassing anxiety, depression, posttraumatic stress, and conduct problems. Children and youth can initially present with anxiety, depression, or behavioral issues that belie underlying trauma. MATCH allows the flexibility to deal with both the overt and underlying cases of trauma. The MATCH treatment model

works to ensure that children and youth with less overt “developmental” trauma are identified and receive effective and comprehensive trauma treatment services.

Last year 516 children received a MATCH intervention. An additional 5 agencies were trained in MATCH this past year, bringing the total to 15 agencies statewide. An additional 27 clinicians were trained this year, bringing the total number of clinicians trained to 141.

DCF continues to expand access to Cognitive Behavioral Intervention for Trauma in Schools (CBITS); an evidenced based treatment model for children suffering from post-traumatic stress symptoms as a result of trauma experiences in their lives. Seventeen school districts and over 46 schools are offering CBITS across the state. To date, 806 students have received treatment in school and 90% have successfully completed the intervention with an additional 10% partially completing the treatment course. One percent were referred on to other treatment options. There was a 41% reduction in PTSD symptoms, a 19% reduction in behavior problems from pre to post assessment, indicating significant improvements.

The statewide EMPS Mobile Crisis Service that DCF funds and oversees has staff trained in trauma principles and conducting trauma screening. This infuses trauma informed care in the state’s crisis intervention. DCF has also been involved in providing pediatric primary care providers, school personnel and police with training on identifying and responding to child and youth trauma.

As part of the federal grant from the Administration on Children and Families, in 2013 DCF implemented a statewide trauma training and universal trauma screening. All DCF staff were trained in using the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit. This training has been embedded into preservice training for all new hires. The staff were also trained to administer a brief, standardized trauma screening tool. Now all children who enter placement are screened for trauma exposure and traumatic stress symptoms, and those deemed at risk are referred for further assessment by clinicians trained in trauma assessments and trauma-focused treatments. The goal is to identify children suffering from traumatic stress symptoms as early as possible and to connect them to appropriate services. Providers are also now utilizing the screening tool for both clinical and non clinical services

Infant Mental Health

In 2011, The CT Department of Children and Families (DCF) was awarded the Early Childhood Child Welfare grant, “Strengthening Families, Infant Mental Health” through a partnership with the CT Head Start State Collaboration Office, Head Start/Early Head Start and the Connecticut Association for Infant Mental Health, which provided an intensive series of eight trainings on infant mental health in the Hartford/Manchester DCF Region.

The trainings were designed to create a shared knowledge base for staff, to promote a unified approach for working with families with complex needs and to enhance working relationships among staff from the various disciplines.

The eight full day training series has, of this year, been delivered to DCF staff and Community Providers in all six regions. The training's focus is on working with young children and their families who are dealing with unresolved loss and trauma and how that impacts relationships, particularly their relationships with their infants and toddlers. The topics will be related to the Competencies for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®.

An average of 40-50 DCF staff and their partners have attended each series. Topics included "Understanding Infant/Toddlers and Their Families;" attachment, brain development, temperament, separation, sensory integration, the Challenges of Unresolved Loss and Traumas; Reflective Practice; Infusing a Trauma Lens into Infant Mental Health Practice; Cultural Sensitivity in Relationship-Focused Settings; Assessments and Referrals and Successful Visitation for parents and infants/toddlers. Continuing education credits have been offered by the Academy to social workers. In addition, reflective supervision training was provided and practice in reflective supervision was offered through face-to-face coaching sessions.

The response to the training series has been overwhelmingly positive. The CT-AIMH and the Department are planning to offer two statewide training eight session training series in the coming year.

Family/Caregiver Involvement

Connecticut has long-term, well-organized and effective consumer, family, and advocacy organizations. These include, but are not limited to: FAVOR our statewide behavioral health family organization, Children's Behavioral Health Advisory Council (CBHAC), State Advisory Council (SAC), Regional Advisory Council (RAC), Youth Advisory Boards and others. (Please refer to Section 1 for details). The Mental Health Block Grant (MHBG) state plan is informed by CBHAC and its MHBG subcommittee. Families and consumers also participate in reviewing bidder proposals for new or re-procured programs and services, learning collaboratives such as the family engagement and TF-CBT collaboratives for outpatient clinics, and various committees to evaluate programs, develop new services and initiatives, and implement plans.

At the direct service level, there are care coordinators, family engagement specialists, intensive care managers (CT BHP), child-specific team meetings for non-DCF involved children, child and family team meetings for DCF-involved children, and other resources to assist families in successfully connecting with and effectively utilizing appropriate resources.

Collaboration Within and Across Agencies and Systems

Efforts aimed at coordinating services at the community level occur across child welfare, juvenile justice, adult and children's behavioral health, developmental, and healthcare service systems. The goal is to promote more efficient and integrated service delivery. At the state level several councils and boards exist to assist in the planning and coordination of behavioral health services. Please refer to Section 1, pages 6-9 for examples.

Husky A (Medicaid) and Husky B (CHIP - Child Health Insurance Program)

Husky A and B are the cornerstone of Connecticut's health care infrastructure for children, parents, and pregnant women whose income are near or under 185% of the Federal Poverty line.

Medicaid provides health insurance for 291,000 low income children in Connecticut. Children make up 44.8 percent of Connecticut's Medicaid population. Each Medicaid-eligible child costs Connecticut just $3,465 per year, on average, compared to Average costs per adult Medicaid enrollee of $6,075. An estimated 25,000 – or 3.3 percent of Connecticut's children under 18 are uninsured. For families of four in Connecticut, children are eligible for Medicaid with family income up to $48,843.

CT continues to directly reimburse providers for health care but utilizes a private, not-for-profit contractor (Community Health Network of Connecticut) as the Administrative Service organization (ASO), to provide administrative support functions, such as assisting families in accessing healthcare, conducting outreach to enroll providers, and tracking utilization of and access to services.

Connecticut continues its relationship with Value Options as the ASO for behavioral health services for adults and children with Medicaid. Value Options is an integral part of the Connecticut Behavioral Health Partnership (CTBHP) with DCF, Department of Social Service, and (state Medicaid dept.) Department of Mental Health and Addiction Services, and a legislative oversight committee that provides for a systems-of-care, data-informed and innovative approach to behavioral health care for children and youth in Connecticut.

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State of Connecticut
Combined SAPT/CMHS Block Grant Application
Federal Fiscal Year (FFY) 2018-2019

Adult Services

Introduction

The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) prepared the State of Connecticut FFY 2018-2019 combined Block Grant application. DCF contributed only to the development of the Community Mental Health Services (CMHS) Block Grant, as Connecticut has a consolidated child welfare agency. Both the Substance Abuse Prevention and Treatment (SAPT) and CMHS Block Grant components were developed in close collaboration with Connecticut's State Behavioral Health Planning Council (SBHPC), having transitioned the State Mental Health Planning Council to encompass substance use services as of October 2012.

DMHAS' purpose is to assist persons with psychiatric and substance use disorders to recover and sustain their health through delivery of high quality services that are person-centered, value-driven, promote hope, improve overall health (including physical) and are anchored to a recovery-oriented system of care. DMHAS' system of care is predicated on the belief that the majority of people with mental illness and/or substance use disorders can and should be treated in community settings, and that inpatient treatment should be used only when necessary to meet the best interests of the client. Since the merger of Connecticut's mental health and addiction service agencies in July 1995, DMHAS has expanded its vision to incorporate the growing body of promising behavioral health service practices. During that time, DMHAS has invested its collective energy in promoting a behavioral health service system that is culturally competent and rooted in evidence-based services.

DMHAS is responsible for providing a full range of behavioral health treatment services to adults (age 18 and older). This includes inpatient hospitalization and detoxification, residential rehabilitation, outpatient clinical services, 24-hour emergency care, day treatment and other partial hospitalization, psychosocial and vocational rehabilitation, restoration to competency and forensic services (including jail diversion programs), outreach services for persons with serious mental illness who are homeless, and comprehensive community-based behavioral health treatment and recovery support services. The department manages a network of Local Mental Health Authorities (LMHAs) and community-based private nonprofits to deliver behavioral health treatment and supports at the community level. It also maintains close working relationships with its statutorily defined planning entities, the Regional Action Councils (RACs) and Regional Mental Health Boards (RMHBs), as well as advocacy agencies, families, consumers/persons in recovery, and other state agencies in its efforts to deliver the most effective treatment and recovery support services needed.

During state fiscal year (SFY) 2016, DMHAS provided and/or funded behavioral health services to over 112,000 individuals, through its inpatient, outpatient, and recovery support programs. Over 100,000 persons were recipients of prevention and health promotion activities in the Institute of Medicine (IOM) categories of selected and indicated, while over a million persons were potential target recipients of some form of universal prevention effort conducted within the state.

Behavioral Health Assessment and Plan

A. Overview

Connecticut Demographic Data

Connecticut is a small state with a net land area of 4,842 square miles and an average of 742 people per square mile. It has a total population of 3,590,886 according to the U.S. Census Bureau Quick Facts – as of July 1, 2015, which represents less than a 1% decrease from the 2013 census figure. Major population areas are Bridgeport, Hartford, New Haven, Stamford and Waterbury. Of the 169 incorporated towns/cities in Connecticut, 68 are designated as rural, based on the Office of Rural Health (ORH) definition (census less than 10,000 **and** population density of 500 or less people per square mile). The total rural population of Connecticut is 331,094. There is no county government. State agencies provide health and human services statewide or at the regional level with various regional geographic configurations.

According to the July 1, 2015 U.S. Census Bureau estimates, Connecticut's racial composition is as follows:

- 80.8% White/Caucasian
- 11.6% Black/African American
- 4.6% Asian
- 0.5% American Indian/Alaska Native
- 0.1% Native Hawaiian/Other Pacific Islander
- 2.2% Two or more races

Hispanic/Latinos comprise 15.4% of the total population of Connecticut.

There was a very slight population decline from 2013 to 2015. Connecticut's population continues to age as 15.8% of its residents are age 65 or older. There was a slight increase in the percentage of Hispanic/Latino residents (from 14.7% to 15.4%) and a slight decrease in the percentage of white/Caucasian residents (from 81.6% to 80.8%). Nearly 14% (13.9%) of residents were foreign born and in 21.9% of households, a language other than English is spoken (for persons 5+). Connecticut is a well-educated state with 89.9% having at least a high school diploma and 37.6% with at least a Bachelor's Degree. The median

household income is over $70,000, but 10.5% are people in poverty. There are 199,331 persons identified as veterans or 6% of the Connecticut population.

DMHAS Organizational Structure

Overview

DMHAS' **mission** is "to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect." DMHAS' mission statement sets forth the department's vision and philosophy, providing the guiding principles upon which services are delivered. The values that define DMHAS' guiding principles, and to which DMHAS is strongly committed, are Quality, Responsibility, Diversity, Integrity, Respect, Empowerment, Collaboration, Hope, Trust, Communication and Recovery.

DMHAS is Connecticut's State Mental Health Authority (SMHA) and Single State Agency (SSA), and is a member of the Governor's Cabinet. It is an independent state agency having statutory responsibility to promote and administer comprehensive behavioral health preventive and treatment services. DMHAS operates, funds and coordinates inpatient and community-based behavioral health services for adults (18 and older) having substance use and/or psychiatric disorders. DMHAS is responsible for the state's behavioral health general funds, CMHS and SAPT block grant allocations and manages the clinical aspects of the Medicaid Behavioral Health Services Partnership for adults.

While the department's prevention services are available to Connecticut citizens of all ages, DMHAS' mandate is to treat **adults** with psychiatric and/or substance use disorders that lack the financial means to obtain such services on their own. DMHAS also provides programs for individuals with special needs (e.g., AIDS/HIV, problem gamblers, substance abusing pregnant women, etc.) and defined target populations (e.g., young adults, including those transitioning out of the Department of Children and Families (DCF)'s service system, those involved with the criminal justice system) as well as persons with serious mental illness (SMI) residing in nursing homes, military personnel and their families, and persons who are homeless.

DMHAS directly operates Connecticut Valley Hospital (CVH) which provides an inpatient level of care for those with serious psychiatric conditions and medically managed detoxification and residential rehabilitation services for those with substance use disorders (SUD).DMHAS contracts with a number of community general hospitals and one private psychiatric hospital (Natchaug) for inpatient and ambulatory care. Inpatient psychiatric beds are also located at four of the state's Local Mental Health Authorities (LMHAs), namely, Connecticut Mental Health Center (CMHC), Capitol Region Mental Health Center (CRMHC), Greater Bridgeport Community Mental Health Center (GBCMHC) and the Southeastern

Mental Health Authority (SMHA). Community addiction treatment services are delivered by a vast network of private nonprofit providers and programs across all levels of care.

DMHAS directly operates the mental health service system for persons with SMI at the regional and local level through a network of state-operated and state-funded community services and supports. Included in this network are thirteen LMHAs statewide, six DMHAS-operated and seven DMHAS-funded, along with over ninety affiliated private nonprofit community-based organizations. LMHAs are the sub-state administrative and direct care component for the delivery and coordination of mental health services across the state. LMHAs develop, maintain, and manage a comprehensive system of mental health treatment, recovery support, and rehabilitative services for designated local service areas known as “catchment areas”.

DMHAS’ prevention and health promotion services are delivered through close collaboration with the Regional Action Councils (RACs) and Local Prevention Councils (LPCs) across the state. The department works directly with communities including schools, workplaces, and neighborhoods to nurture supportive and safe environments in support of drug-free lives.

Service Delivery System – Mental Health

Psychiatric Inpatient Services

DMHAS currently provides acute psychiatric inpatient services to adults at three state-operated facilities including Connecticut Valley Hospital (CVH), Greater Bridgeport Mental Health Center (GBMHC), and Connecticut Mental Health Center (CMHC). In addition to these state hospitals, DMHAS operates two LMHA facilities that manage sub-acute beds, including Southeastern Connecticut Mental Health System (SMHA) and Capitol Region Mental Health Center (CRMHC). In concert with DMHAS’ overall approach to illness management, the inpatient facilities provide a variety of skills-based and recovery-oriented interventions focused on reducing acute psychiatric symptoms and improving level of functioning for adults who are gravely disabled by mental illness. The ultimate goal of inpatient care is to enable the person with SMI to live in the most integrated setting. All DMHAS inpatient facilities provide therapeutic programs designed to meet the treatment needs of adults in the most cost-effective manner possible. Specialty services provided include Geriatrics, Traumatic/Acquired Brain Injury, Cognitive Rehabilitation, Co-Occurring, Dialectical Behavior Therapy and Forensic Services.

The Whiting Forensic Division, located on the campus of CVH, operates 232 beds. Services are provided to individuals who are admitted under the following categories:

- Psychiatric Security Review Board (PSRB) commitment

- Criminal court order for restoration of competency to stand trial
- Civil commitment (voluntary or involuntary)
- Transfer from the Department of Correction (during period of incarceration or at end of sentence)

In 2010, DMHAS consolidated inpatient psychiatric beds by relocating the former Cedar Ridge Hospital to its CVH hospital campus. The department restructured its existing inpatient facilities to maximize resources, pool staff and clinical expertise, and provide for the efficient delivery of quality services. The Young Adult Services Program increased capacity with the move to the CVH campus and a co-occurring inpatient unit was established at the GBMHC facility. Lastly, the department, in collaboration with the states' Medicaid Authority (Department of Social Services – DSS), procured intermediate duration acute care beds in the community to meet the needs of those individuals appropriate for this level of care.

Contracted Inpatient Services

Comprehensive, hospital-based psychiatric services are those clinical and medical activities and interventions necessary for the stabilization of the individual's psychiatric or co-occurring psychiatric and substance use disorder, including at a minimum, thorough psychiatric and substance use evaluations, and medication evaluation and management. DMHAS has contracts with twelve general hospitals and one private psychiatric hospital to provide acute inpatient services on a fee-for-service basis. DMHAS uses a statewide utilization management/review process with a dedicated staff person and input from the DMHAS Medical Director.

Forensic Services

Community Forensic Services

The Division of Forensic Services (DFS) was established to implement and coordinate specialty skilled evaluation and treatment services for individuals with serious mental illness and/or substance use disorders who become involved in the criminal justice system, and to serve the courts and other components of the criminal justice system. Forensic services are directed at efforts intended to promote recovery and prevent or limit criminal justice system involvement to the extent possible, to promote public safety and to coordinate activities with other state and private agencies. Services within DFS span the continuum of the criminal justice system from pre-booking to end of sentence after incarceration and return to the community.

I. Pre-Booking Diversion

DMHAS Crisis Intervention Team (CIT)

CIT is a pre-booking diversion program for police, in collaboration with mental health professionals, to divert individuals at the time of initial contact with law

enforcement. The CIT program trains police officers to interact in a constructive manner with individuals having psychiatric disorders.

The DMHAS CIT program was established in 2004 in collaboration with the National Alliance on Mental Illness – CT (NAMI-CT), local police departments, and the Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE). It was implemented with federal funds and is now entirely state funded. The DMHAS program expands on the Memphis, Tennessee CIT model by funding positions for clinicians, from DMHAS-funded LMHAs, who are trained and designated to work in collaboration with police departments. This critical link between mental health professionals and law enforcement allows for immediate and follow-up engagement and linking individuals to treatment and other needed services.

II. Post-Booking Diversion

All criminal courts in CT are state-operated and the state made a policy decision to avoid specific courts or dockets for the mental health population and, instead, provide mental health jail diversion programming in all criminal courts.

Jail Diversion/Court Liaison Program (JD; statewide)
Clinicians in all 20 arraignment courts screen adult defendants with mental illness, including SMI and co-occurring conditions, and can offer community treatment options in lieu of jail while the case proceeds through the court process. JD makes referrals for services, monitors compliance, and reports compliance to court.

Woman's Jail Diversion (JDW; New Britain, Bristol, New Haven)
JDW offers a full range of services to women with trauma sequelae, most with substance abuse, who are at risk of incarceration pretrial or at risk of violation while on parole/probation. Services include clinical, medication, community support, limited temporary housing, and client supports.

Jail Diversion Veterans (JDVets; Norwich, New London, Danielson, Middletown)
JDVets targets veterans of the Iraq and Afghanistan wars as well as older veterans and those active in the military who have current criminal charges. The program can offer community treatment options in lieu of jail while the case proceeds through the court process. JDVets refers clients for clinical services and specialized veteran's services, monitors compliance, and reports compliance to court. The program is expanding to provide statewide consultation to JD staff.

Jail Diversion Substance Abuse (JDSA; Hartford)
JDSA targets adults with substance dependence in need of immediate admission to residential detox and/or intensive residential treatment on the day of arraignment or rapid admission to IOP. JDSA offers intensive case management, sober house rent, other transitional housing options, client supports, monitors compliance, and reports compliance to court.

Alternative Drug Intervention (ADI; New Haven)
The ADI program offers full services to pretrial defendants with substance dependence in New Haven court (mostly men; women go into the JD Women's program). Services include clinical, medication, case management, and client supports.

Pretrial Intervention Program (PTIP; statewide)
Per state statute, the PTIP program provides: 1) evaluations for placement recommendation for "first-offender" DUI and drug possession cases and 2) Alcohol Education groups, Drug Education groups, or referral to substance abuse treatment programs.

III. Re-entry

DOC-DMHAS Referral Process (statewide)
All discharging sentenced inmates with SMI are referred to the DMHAS Division of Forensic Services and assigned to an LMHA for discharge planning and engagement. Some of these individuals are admitted to CORP.

Connecticut Offender Re-entry Program (CORP; 5 sites; 4 prisons)
CORP provides pre-release (6-18 months) engagement, discharge planning, and twice weekly skills groups in DOC by LMHA staff for sentenced inmates with SMI. Also provided are post-release support, temporary housing, and client supports.

Transitional Case Management (TCM; 4 sites; 5 prisons)
TCM offers pre-release (3-4 months) engagement and discharge planning in DOC by PNPs and post-release outpatient substance abuse treatment, case management, and temporary housing for sentenced men with substance dependence.

IV. Programs That Serve Multiple Points In The Criminal Justice System

Community Recovery Engagement Support and Treatment (CREST; New Haven)
The CREST program is a day reporting center for adults with SMI under court/probation/parole/PSRB supervision. Services include case management and skills groups, as well as clinical services provided by the LMHA.

Sierra Center Pretrial Transitional Residential Program (New Haven)
DFS funds 9 beds and CSSD funds 14 beds for pretrial defendants with SMI statewide who are released from jail. The Sierra center provides skill-building, programming and intensive supervision. The LMHA provides clinical services and case management. Most clients also attend CREST.

Advanced Supervision and Intervention Support Team (ASIST; 9 sites)

ASIST combines AIC supervision with clinical support (LMHAs and PNPs) and case management for adults with moderate-serious mental illness under court/probation/parole supervision. ASIST is collaboratively funded/managed by DMHAS, CSSD, and DOC. Some temporary housing and client supports are provided.

Forensic Supportive Housing (FSH; 3 sites)
FSH offers permanent supportive housing services with Rental Assistance Program (RAP) certificates for Division of Forensic Services clients with SMI and patients with SMI discharging from state psychiatric beds at risk of incarceration. It includes temporary housing, temporary rental assistance before RAP is granted, and client supports.

Forensic Housing Assistance Fund (FHAF)
FHAF uses funds in the Housing Assistance Fund (HAF) that are allocated for clients of DFS programs. The program provides temporary funds to help clients with SMI secure permanent housing prior to receipt of a permanent rental subsidy. It subsidizes rents and provides a no-interest loan for security deposit for an apartment and utilities.

Forensic Transitional Housing
Transitional housing beds are provided in multiple locations so that homelessness is not a barrier for adults who are diverted or re-entering the community.

Community based Treatment Services

The department's **Community Services Division (CSD)** has direct responsibility for overseeing all DMHAS contracted services, which includes funded LMHAs (and their affiliates) for behavioral health services as well as all funded community nonprofit addiction service providers. CSD activities include:

- Monitoring the contracted private nonprofit providers that make up the DMHAS system of behavioral health, including private nonprofit substance use treatment providers and Local Mental Health Authorities, to ensure contract compliance;
- Identifying service gaps, new services, and system changes that enhance efficiency, increase access, and support people living successfully in recovery;
- Facilitating the implementation of department initiatives intended to enhance or create service capacity to increase service effectiveness;
- Collaborating with the department's Evaluation, Quality Management and Improvement (EQMI) division to monitor provider data including admission and discharge information, demographics and services delivered; and
- Responding to and resolving consumer and family questions and concerns.

CSD provides oversight to the seven private nonprofit contracted LMHAs and ensures they receive information regarding department policies and system initiatives. CSD provides a consistent approach in its collaboration with LMHAs to operationalize fiscal, administrative, and clinical responsibilities, as well as DMHAS initiatives, at the local level. CSD monitors the activities of the LMHAs in allocating resources among programs and facilities in response to system needs providing a link between LMHAs and DMHAS' Office of the Commissioner. This organizational structure recognizes variations in local needs and provides the essential framework for achieving DMHAS' objectives and operations. The six state-operated LMHAs report directly to the DMHAS Commissioner. CSD Regional Staff coordinates with the state-operated LMHAs regarding the nonprofit affiliate agencies in order to assure access and coverage to mental health services.

LMHA functions usually include:

- Service coordination and care and case management in a recovery-oriented environment
- Critical linkages with other agencies for service needs, such as housing and entitlements
- Crisis intervention
- Program development and management
- Implementation of DMHAS initiatives
- Budget development and management
- Contract oversight
- Utilization review/quality assurance (QA)/quality improvement (QI)
- Information system management
- Community relations and education, and consumer/family input into service system evaluation and planning

In addition to DMHAS-operated and –funded programs, behavioral health services in Connecticut are delivered through other public and private providers such as:

- Private mental health practitioners
- Private nonprofit mental health providers not funded by DMHAS
- DOC for prison inmates
- Board of Pardons and Paroles for persons paroled into the community
- JB-CSSD for probationers
- Federally Qualified Health Centers, Health Maintenance Organizations, and primary care physicians
- U.S. Department of Veterans' Affairs, including inpatient psychiatric beds, and outpatient and counseling services at two VA medical centers, six community-based outpatient clinics and four Veterans' Centers
- Volunteer-run, peer supported services and self-help groups

Mobile Crisis and Respite Care

Mobile Emergency Crisis Services are defined as mobile, readily accessible, rapid response, short term services for individuals eighteen (18) or older and their families experiencing episodes of acute behavioral health crises. These services are delivered with appropriate safety measures in safe settings such as at the Local Mental Health Authority (LMHA) or in other community settings through the use of mobile emergency crisis teams. Mobile emergency crisis services provide concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, stabilize psychiatric symptoms, behavioral, and situational problems, and whenever possible, avert the need for hospitalization. Mobile emergency crisis services focus on evaluation, stabilization and supports and activities may include: assessment, evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further continuous care and assistance as required. Mobile emergency crisis clinicians collaborate with and assist local police officers to de-escalate crises and provide diversion to alternative settings rather than incarcerations. DMHAS has implemented the Crisis Intervention Team (CIT) model, a best practice designed to promote safety for persons in crisis, the community, and the police officers who respond to crisis calls. The CIT trained clinicians work collaboratively with police departments and, when available, respond to crisis calls with the police.

Crisis Respite Services are primarily utilized as an adjunct service for DMHAS Mobile Crisis Services, DMHAS provides Crisis Respite Services on a statewide basis. These programs provide a structured community bed setting staffed 24/7 to individuals age 18 and older, with access to licensed prescribers and clinical staff. Services include: medication monitoring, stabilization activities, and an array of outpatient interventions. Crisis Respite services provide further crisis supports to those in behavioral health/psychiatric distress and/or are having extreme conflict in their current living situation that is of such intensity or duration that it may require such services in order to avoid hospitalization. Crisis Respite beds are available for use within the Mobile Crisis Services programming and as part of the continuum of care in order to stabilize individuals, avert psychiatric inpatient hospitalization, and return persons to their current residence and optimum recovery.

Outpatient Services are professionally directed services that include evaluations and diagnostic assessments; biopsychosocial histories, including identification of strengths and recovery supports; a synthesis of the assessments and history that results in the identification of treatment goals; treatment activities and interventions; and recovery services. Such services are provided in regularly scheduled sessions and nonscheduled visits as needed, and include individual, group, and family therapy, as well as medication management.

Group Homes are congregate community residences that are staffed 24/7 and provide a set of residential and rehabilitative services. Individuals residing in the group home have significant skill deficits in the areas of self-care and

independent living as a result of their psychiatric disability requiring a non-hospital, structured and supervised community-based residence. A written plan of care or initial assessment of the need for services is recommended by a physician or other licensed practitioner. Group homes are intended primarily as a step-down service from inpatient hospitalization.

Intensive Residential Mental Health Treatment is a highly structured setting that provides a set of recovery-oriented residential and rehabilitative services with 24 hour staff supervision. Some individuals admitted may also have co-occurring medical conditions, such as diabetes and obesity, which are complicated by an adjunct psychiatric disorder. Admissions come directly from a state-operated inpatient facility and must be approved through the department's Medical Director or his designee.

Supervised Housing is a set of recovery-oriented services provided 24/7 by on-site staff. Staff provides individuals with assistance in all areas of daily living, community integration, education assistance and counseling, management of personal financial resources and budgeting, referrals to all necessary services, meal preparation, improving communication skills, and use of leisure time. Other services include case management and, as needed, housing assistance from the housing resource coordinator to aid individuals in finding, obtaining, and keeping safe affordable housing.

Supportive Housing fosters the development of long-term solutions to the housing and service needs of families and individuals coping with psychiatric disabilities and consists of transitional and/or permanent housing subsidies with funding for supportive services (see **Evidence-Based Practices**).

Community Support Services

Support services provided in the community are designed to assist persons with serious mental illness to function as independently and self-sufficiently as possible to enhance their chances of successful community placement. Both include the use of peer staff to draw on their experiences with SMI and co-occurring disorders, and to further facilitate recovery and community participation of the individuals served.

Assertive Community Treatment (ACT) services are evidence-based practices provided by mobile, community-based staff operating as multidisciplinary teams of professionals, paraprofessionals and recovery support specialists who have been specifically trained to provide ACT services. ACT services include intensive engagement, skill building, community support, crisis services and treatment interventions. There are 10 ACT teams across the state (5 state-operated and 5 PNP).

Community Support Programs (CSP) are available statewide to assist adults who are interested in skill building and/or need more **Targeted Case Management (TCM)** services (i.e., at least three hours face to face service/month). Across the state there are 22 PNP agencies with 26 CSP programs and 6 state-operated agencies with 9 CSP programs – some agencies have multiple sites. CSP services focus on building and maintaining a relationship with the individual while delivering:

- Targeted case management (TCM)
- Rehabilitative, skill building interventions and activities
- Facilitating connections to the individual's community recovery supports
- Emphasizing individual choice, goals and recovery
- Providing peer support

Mental Health Recovery Support Services

Social Rehabilitative Services provide supportive, flexible environments and activities to enhance daily living skills, interpersonal skill building, life management and pre-vocational skills that are necessary for successful integration into a community environment. Pre-vocational activities may include temporary, transitional, or volunteer work assignments. Activities include access to peer groups and relationships.

Parenting Support and Parental Rights Services maximize opportunities for parents with psychiatric disabilities to protect their parental rights, establish and/or maintain custody of their children, and sustain recovery through individualized, home-based services and supports that may be helpful, and to promote the utilization of temporary guardianships.

Recovery Support Specialists are persons in recovery who have received training to become certified to work as part of multi-disciplinary community-based treatment teams along with psychiatrists, social workers, and case managers to assist individuals with mental illness who have not been responsive to traditional forms of treatment. Recovery Support Specialists provide outreach, support, and follow-up services to individuals in the community including, but not limited to, locations such as emergency rooms, jails, homeless shelters, and outpatient services.

Recovery Support Training Program provides consumer-operated recovery/advocacy training academies that train persons with lived experience in the following technologies: Certified Recovery Specialist Training; General System & Legislative Advocacy (in English and Spanish); Peer Bridging; Wellness Recovery Action Planning (WRAP); Intentional Peer Support (IPS); and Pathways to Recovery. Classes are conducted in self-esteem and in developing networks of support and specialized classes are offered in Certified Hearing Voices Support Group Facilitation and Peer Support in Forensic Facilities. These

services provide a way for consumers to identify their resources and develop wellness strategies, to make proactive crisis plans when not in crisis; as well as to prepare them to conduct educational presentations in their communities and organizations. Recovery University training is overseen by Advocacy Unlimited (AU).

Peer Support – Vocational Services provide peer-based vocational supports to individuals with psychiatric disabilities. Through the use of trained peer mentors, individuals in recovery are provided opportunities that aid in the development and pursuit of vocational goals consistent with the individual's recovery. Supports include: assistance with finding, obtaining, and maintaining stable employment; and promoting an environment of understanding and respect in which the individual is supported in their recovery. These services foster peer-to-peer assistance to support individuals in recovery toward stable employment and economic self-sufficiency.

Consumer Peer Support in General Hospital Outpatient Department is directed at improving the quality of services and interactions experienced by individuals with psychiatric disabilities who seek outpatient treatment in general hospitals. Using consumers who have completed a training program, these peer advocates assist individuals accessing outpatient care in understanding hospital policies and procedures, and assuring that individuals' rights are respected.

Intensive, Community-Based Peer Bridging Services are services contracted through Advocacy Unlimited in which certified Recovery Support Specialists with lived psychiatric experience provide outreach, engagement and support in the community to adults with SPMI who are at risk for, or currently involved with, the Probate Court system. Peer Bridgers operate in hospitals, emergency rooms, jails or other community locations where their services are needed. The Peer Bridgers develop relationships with community resources and supports and function as liaisons for the program participants, including providing transportation. The Peer Bridgers provide long-term support for persons with SPMI to function optimally in the community.

Special High School Education Services

DMHAS is mandated by State and Federal statutes to provide education and related services (vocational, speech, occupational and physical therapy, and physical education) to all "special education" eligible 18 – 21 year old residents of DMHAS facilities, who have not graduated from high school and are interested in continuing their education while in residence. Accomplishment of this task requires the screening of all 18 – 21 year old inpatient admissions to DMHAS facilities.

A large number of students who turn 18 who are in need of acute care at one of DMHAS' adult psychiatric facilities are those transitioning from the care of DCF.

DMHAS Special Education Services continues to be effective in designing unique and successful post-recovery education programs that are then implemented in the community. There is a high level of collaboration between DMHAS Special Education Services and DMHAS Young Adult Services as 18 – 21 year old clients are discharged to supportive community settings.

Supportive Housing

Permanent Supportive Housing programs provide in-home wrap around services to individuals and families with children who are experiencing homelessness and are diagnosed with a mental health or substance use disorder. Services include assistance with securing permanent housing, education about appropriate tenancy skills, knowledge of tenants' rights and responsibilities, money management and household budgeting. Based on an individual needs assessment, the services offered include access to clinical, medical, social, educational, rehabilitative, employment and other services essential to achieving optimal quality of life and community living. Various levels of support are available to program participants and are offered indefinitely, as needed. Additionally, DMHAS follows the "housing first" model which states that there are no conditions placed on an individual or family before entering housing. There are no additional provisions related to disability or services added to any lease or housing contract; to remain housed a person must comply with the lease.

Supported Employment and Education Services

Employment and educational services are integral to DMHAS' goal of offering a recovery-oriented system of care for persons in recovery who experience behavioral health conditions. DMHAS has put protocols in place to insure that consumers have both the necessary opportunities and supports to become involved in employment and education activities that have been shown to promote recovery and facilitate successful community integration. DMHAS funds 30 agencies that provide a broad menu of employment and education services. In 2016, DMHAS had to reduce supported employment contract by $1.3 million due to reductions in state funding. Current contracts focus DMHAS funding on Individual Placement and Support (IPS) evidence-based supported employment and preferred employment practices as well as emerging supported education best practices. The DMHAS employment manager conducts fidelity reviews every two years at each site to insure on-going quality improvement. Extensive feedback is offered along with technical assistance and training to any and all providers who need or request assistance with program/staff capacity building. DMHAS continues extensive collaboration with the Department of Rehabilitation Services (DORS), Connecticut's Vocational Rehabilitation Agency. DMHAS and DPRS jointly fund a manager that works to bridge our complementary employment services at the state and local levels.

With the award of a new 5-year SAMHSA grant to deliver Supported Employment services to underserved populations, and in efforts to expand employment services, DMHAS has contracted with two additional providers to deliver modified Individual Placement and Support (IPS) supported employment services serving the Hispanic population in the greater Hartford area and persons with criminal justice involvement in the greater New Haven area.

Continuum of Substance Use Treatment Services

Overview

Treatment and rehabilitation programs utilize a variety of strategies, all of which seek to provide appropriate services to address substance use disorders. These strategies include:

- **Pre-Treatment**: services and activities necessary for a client to become engaged in and/or enter treatment
- **Medication Assisted Treatment and Ambulatory Drug Detoxification**: medication assisted services, counseling and management of withdrawal for heroin and other opioids in a non-residential setting
- **Residential Detoxification**: medical management of the withdrawal from alcohol and drugs along with case management linkages to treatment
- **Residential Rehabilitation**: treatment services in a structured, therapeutic environment for individuals who need assistance in developing and establishing a drug free lifestyle in recovery. Such services include various levels of residential care, from intensive to long-term.
- **Outpatient (standard and intensive)**: individual, group and family counseling services for individuals with substance use or co-occurring substance use and psychiatric disorders, and families and significant others
- **Treatment Support Services**: ancillary services that support an individual's engagement and/or retention in treatment and recovery, including case management, transportation, housing and vocational services
- **Continued Care and Recovery Support Services**: supportive services that provide post-treatment assistance to those individuals working on and in recovery such as housing, transportation, employment services and relapse prevention. In addition, supports provided include telephone peer support and Recovery Centers. Mutual help organizations, e.g., 12-step programs, provide a supportive network, which encourages individuals in their efforts to maintain a substance-free lifestyle in the community.

The above treatment modalities are intended to focus on the following service priorities:

- Services geared to the medical management of the withdrawal from alcohol and other drugs

- Residential services intended to impact significant levels of the personal and social effects of substance use disorders
- Ambulatory services to assist the individual in re-entering or remaining in the community
- Services for individuals who are opioid dependent are intended to provide opioid replacement therapy along with supportive rehabilitative services to facilitate successful lives in recovery

Detoxification Services

Medically Managed Detoxification

Medically managed detoxification services, provided in a private freestanding psychiatric hospital, general hospital or state-operated facility, are medically directed treatments of a substance use disorder, where the individual's admission is the result of a serious or dangerous substance dependence that requires a medical evaluation and 24/7 medical withdrawal management. For individuals who have co-occurring psychiatric and substance use disorders, assessment and management are available.

Medically Monitored (Residential) Detoxification

Medically monitored detoxification is provided in a residential facility licensed by the Department of Public Health (DPH) to offer residential detoxification and evaluation; it involves treatment of substance use dependence when 24-hour medical and nursing oversight is required. Comprehensive evaluations and withdrawal management are provided as well as short-term counseling, connections to treatment, and referrals to other supports.

Residential Rehabilitation Services

Intensive Residential Rehabilitation – Co-Occurring

Intensive Residential Rehabilitation – Co-Occurring services are residential services provided in a facility licensed by the DPH to offer intensive residential treatment, or in a state-operated facility that provides medically and behaviorally-directed concurrent treatment of co-occurring psychiatric and substance use disorders where an individual's admission requires continued stabilization of psychiatric symptoms as well as substance use treatment. The program is utilized when 24-hour medical and nursing supervision are required to provide evaluation, medication management, and symptom stabilization. Other intensive services include those of a rehabilitative nature such as illness education and self-management and other skill building.

Intensive Residential Rehabilitation

Intensive Residential Rehabilitation treatment for substance dependence or co-occurring disorders is a residential service provided in a facility licensed by DPH to offer intensive residential treatment, or in a state-operated facility. These services are provided in a 24-hour setting and are intended to treat individuals

with substance use or co-occurring disorders who require an intensive rehabilitation program. Services are provided within a 15 to 30 day period and include assessment, medical and psychiatric evaluation if indicated, and an intensive regimen of treatment modalities including individual and family therapy, specialty groups, psychosocial education, orientation to AA or similar support groups, and instruction in relapse prevention.

Intermediate/Long-Term Residential
Intermediate or long-term residential treatment for substance use disorders is a service provided in a facility licensed by DPH to offer intermediate or long-term treatment or care and rehabilitation. These residential services are intended to address significant problems with functioning in major life areas due to a substance use disorder or a co-occurring psychiatric and substance use disorder with the goal of community re-integration and establishing a life in recovery. A minimum of twenty hours per week of treatment and services in a structured recovery environment is provided to individuals who generally remain in treatment for 3 to 6 months.

Long-Term Residential Care
Long-term residential care for substance use disorders is a service provided in a facility licensed by DPH to offer intermediate or long-term treatment or care and rehabilitation. This service is intended for individuals with significant impairment and long-term difficulties with functioning in major life areas due to a substance use disorders or a co-occurring psychiatric and substance use disorder. Services are provided in a structured recovery environment with 24/7 staff supervision, and may include vocational exploration as well as life skills training intended to assist individuals with re-integration into the community and establishing a life in recovery. Individuals generally remain in treatment for 6 to 9 months.

Transitional/Halfway House
Transitional Living and Halfway Houses are licensed by DPH to offer intermediate, long-term treatment, care and rehabilitation. These services are intended for individuals who have experienced significant problems with their behavior and functioning in major life areas due to a substance use disorder, or a co-occurring psychiatric and substance use disorder, and who are ready to re-integrate back into the community and establish a life in recovery. Services are provided in a structured recovery environment with the focus being on obtaining employment and community re-integration.

Ambulatory (Outpatient) Services

Intensive Outpatient Services
Intensive outpatient services offer intensive mental health or substance use disorder treatment for a minimum of three hours per day, three days per week. Services include individual and group therapy, therapeutic activities, case management and a range of other rehabilitative activities.

Veterans Recovery Center (VRC) at Fellowship House
A collaborative effort between DMHAS and the Connecticut Department of Veterans' Affairs (DVA) is the Veterans Recovery Center providing outpatient and an optional four-week intensive outpatient (required 12 hours per week) programs for veterans. Services provided by DMHAS include relapse prevention, 12-step groups, anger management groups, and meditation classes. The Fellowship House is located on the grounds of the DVA under the auspices of DMHAS. The program is designed to assist and support veterans with substance use disorders to achieve their recovery goals. The VRC interfaces with other services on the DVA grounds, including educational and vocational referrals, employment counseling and job placement assistance.

Standard Outpatient
Standard outpatient services provide professionally directed evaluation, treatment and recovery services. Services are provided in regularly scheduled sessions and include individual, group, family therapy, and psychiatric evaluation and medication management. If the program focuses on the needs of seniors (those age 55 and over), information related to older adult services and substance abuse is provided. These senior services are delivered in homes, senior centers, and nursing homes as necessary.

Medication Assisted Treatment
Methadone Maintenance
Methadone maintenance is a non-residential, medically necessary service provided in a state-operated facility, or in a facility licensed by DPH to offer medically necessary chemical maintenance treatment. Methadone maintenance involves regularly scheduled administration of methadone, prescribed at individual dosages, and includes a minimum of one clinical contact per week. More frequent clinical contacts are provided if indicated in the individual's recovery plan. Medical and nursing supervision are provided.

Buprenorphine Maintenance
Buprenorphine maintenance is a non-residential, medically necessary service provided in a state-operated facility, or in a facility licensed by DPH to offer medically necessary chemical maintenance treatment. Buprenorphine maintenance involves regularly scheduled administration of Buprenorphine, prescribed at individual dosages, and includes a minimum of one clinical contact per week. More frequent clinical contacts are provided if indicated in the individual's recovery plan. Medical and nursing supervision are provided. In response to the opioid crisis, DMHAS has applied for and received SAMHSA grant funds which have allowed it to expand buprenorphine access by assisting physicians in its facilities with obtaining the DATA waiver to prescribe, providing guidelines for infrastructure development related to buprenorphine prescribing, and hiring recovery coaches to assist in the process.

Ambulatory Detoxification

Ambulatory detoxification is a non-residential service provided in a private freestanding psychiatric hospital, general hospital, facility licensed by DPH to offer ambulatory chemical detoxification, or a state-operated facility. This service uses prescribed medication, as indicated, to alleviate adverse physical or psychological effects that result from withdrawal from continuous or sustained substance use by an individual who has been evaluated as being medically able to tolerate an outpatient detoxification. Services also include an assessment of needs, including those related to recovery supports and motivation of the individual regarding his/her continuing participation in the treatment process.

Substance Use Support Services

Shelter

Shelter services provide short-term housing to individuals who are homeless and assistance in connecting them with stable housing and clinical services

Recovery House

Recovery Houses are intended for individuals in recovery from substance use or co-occurring disorders who would benefit from a sober living environment to support their recovery. These transitional living environments provide 24-hour temporary housing and support services for persons who present without evidence of intoxication, withdrawal or psychiatric symptoms that would suggest inappropriateness for participation in such a setting. The length of stay for residents is generally less than 90 days. Recovery houses are not licensed and do not offer treatment services.

Recovery Housing

Supported Recovery Housing Services (SRHS) are non-clinical, clean, safe, drug and alcohol-free transitional living environments with **on-site case management services** available at least 8 hours per day, 5 days per week. SRHS provide 24-hour temporary housing and support services for persons with a substance use or co-occurring substance use and psychiatric disorder who present without evidence of intoxication, withdrawal or psychiatric symptoms that would suggest inappropriateness for participation in such a setting. Advanced Behavioral Health (ABH), the department's Administrative Services Organization (ASO), credentials SRHS providers and contracts with them to provide housing and case management services to persons in recovery. In order to be credentialed, an organization must meet certain minimum standards and the homes must maintain certain minimum house rules. DMHAS currently contracts with 14 organizations providing SRHS at 48 locations and with 208 beds (male/female), although providers may have additional non-contracted or self-pay beds. Case management services include assessment, recovery planning, and discharge planning with the goal of linking residents to substance abuse and mental health treatment services, entitlements, employment, permanent housing, and other community supports that promote autonomy. The length of stay for residents is

generally less than 90 days. Recovery or “sober” houses are not licensed and do not offer treatment services.

Standard Case Management
Standard case management programs provide a range of activities to individuals with substance use disorders or co-occurring psychiatric and substance use disorders. Services include linking individuals to necessary clinical, medical, social, educational, rehabilitative, employment, and other services and recovery supports.

Intensive Case Management (ICM)
Intensive case management programs provide a range of activities to individuals with severe substance use disorders or co-occurring psychiatric and substance use disorders. Services include linking individuals to necessary clinical, medical, social, educational, rehabilitative, and vocational or other services. Services may also include intake and assessment, individual recovery planning and supports, medication monitoring and evaluation. Services are intensive and may be provided daily or multiple times a week if necessary. Intensive case management services are generally short in duration with individuals receiving services for 30 to 90 days.

Outreach and Engagement
Outreach and engagement programs provide a range of activities to individuals with behavioral health disorders who are homeless. Activities may be provided utilizing a team model, which includes behavioral health workers and clinical, nursing, and psychiatric staff, and utilizes a wide range of engagement strategies. Activities are directed toward helping individuals acquire necessary clinical, medical, social, educational, rehabilitative, vocational and other services in hopes of achieving optimal quality of life and lives in recovery in the community. Services include intake and assessment, individual service planning and supports, intensive case management services, counseling, medication monitoring and evaluation.

Employment Services
Employment services are an array of activities that assist individuals to identify and select employment options consistent with his/her abilities, interests, and achievements. Services facilitate finding employment as well as supports to attain specific employment and educational objectives.

Transportation
Transportation services, including consumer-operated transportation programs, are provided to individuals receiving services from a department-operated or funded service provider. For persons receiving mental health services, transportation services through TRED can include transporting individuals to various appointment, school programs, shopping centers, and family events. Transportation services for persons receiving substance use services are

provided by Road to recovery (R2R) and are primarily utilized to deliver individuals at an emergency room or department-funded provider agency to another treatment location and any individual who may require transportation from one level of care to another. Plans are underway to expand transportation coverage for persons with substance use disorders in general and specifically for persons with opioid use disorder across the state using R2R for the southern portion and Intercommunity for the northern portion. When persons with opioid use disorder contact the statewide access line (see below), not only will a phone assessment and referral be provided, but transportation as needed to bring the person to the treatment location providing “treatment on demand”.

Access Line
Persons with opioid use disorder who are interested in accessing treatment can call 1-800-563-4086 on a statewide 24/7 basis for initial screening, referral, and transportation if needed, to treatment. This service which was previously only available to one region of the state has been expanded in response to the opioid crisis. The goal is to connect persons struggling with Opioid Use Disorders (OUDs) rapidly to treatment.

Evidence-Based and Best Practices

DMHAS has been supporting the DMHAS-operated and –funded mental health and addiction treatment providers in the use of the following evidence-based and best practices, including:

Assertive Community Treatment (ACT) services are a set of evidence-based practices provided by mobile, community-based staff operating as multidisciplinary teams of professionals, paraprofessionals and recovery support specialists, who have been specifically trained to provide ACT services. ACT crisis services are recovery-oriented, and include intensive engagement, skill building, community support, crisis services, and treatment interventions. There are 10 ACT teams. DMHAS uses the Tool for Measurement of Assertive Community Treatment (TMACT) as a fidelity measure. DMHAS received on-site training and technical assistance from Dr. Lorna Moser, funded by SAMHSA block grant TA, on the administration of this tool.

Integrated Treatment for Individuals with Co-Occurring Disorders. DMHAS knows that a large number of individuals served by the department have both a mental health and a substance use disorder. Mental health and addiction treatment service providers continue to enhance their programming to provide integrated treatment for people with co-occurring disorders. Specialized staff training, consultation, and pilot treatment projects for persons with co-occurring disorders have been put in place over the last twenty years to address the treatment needs of individuals with co-occurring disorders. The thirteen LMHAs

have implemented the Integrated Dual Disorders Treatment (IDDT) model and addiction treatment providers have used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index to guide its integrated care for individuals with co-occurring disorders. Some mental health programs have also gravitated to using the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) instead of the IDDT model to guide their integration efforts. DMHAS created two co-occurring enhanced residential treatment programs that were procured in 2009 and continue today (primarily for quadrant III individuals) and a co-occurring enhanced inpatient unit that started in 2010 continues as well (primarily for quadrant IV individuals).

DMHAS contracted with an IDDT consultant from Dartmouth Medical School for 9 years (2002-2011) and with Dr. Mark McGovern (also from Dartmouth) for about 10 years to train and consult with DMHAS providers on the DDCAT. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and addiction treatment agencies on a combined Co-Occurring and Supervision model for a couple of year. Due to declining resources, DMHAS has had to suspend the Co-Occurring Practice Improvement Collaborative meetings and fidelity reviews.

Dialectical Behavior Therapy (DBT) continues to be implemented in the state-operated LMHAs (6) and inpatient settings. The Connecticut Women's Consortium, as part of its contract with DMHAS, provides DBT trainings.

Supported Employment (SE), using Individual Placement and Support (IPS), is implemented in thirty programs. This evidence-based model is described in their contract language as the scope of work. Fidelity reviews continue to support high fidelity implementation. DMHAS continues to participate in the national supported employment collaborative convened by Dartmouth (now Westat). In fall 2014, DMHAS was awarded a SAMHSA Supported Employment grant to strengthen and expand SE services across the state, particularly for Latinos and individuals with criminal justice involvement.

Supported Education. DMHAS contracts with five regionally-based providers to provide supported education. The department has adopted and uses SAMHSA's Supported Education Fidelity Scale from the EBP toolkit.

Supportive Housing continues with high quality fidelity monitoring and implementation.

Trauma-informed and Trauma-specific services. DMHAS contracts annually with the Connecticut Women's Consortium to provide training, consultation and implementation support for DMHAS' mental health and addiction treatment agencies, through a network of contracted national experts. The Consortium trains professionals annually on trauma-informed care and trauma-specific services, such as Seeking Safety, TREM, M-TREM, Beyond Trauma, and

Helping Men Recover. Gender-responsive services are also part of these offerings, including training/technical assistance from Stephanie Covington.

Medication Assisted Treatment (MAT) is provided through a strong network of methadone providers statewide. The availability of Suboxone has increased. DMHAS continues to support the implementation of MAT throughout all services, so that, for example, individuals with SMI served in our LMHAs have access to FDA-approved medications for substance use disorders.

Other EBPs, such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) are supported and embedded in several other EBPs (e.g., IDDT, DDCAT, and ACT) and other levels of care (e.g., outpatient, residential).

Alternative Services
An Integrative Medicine Committee was established at Connecticut Valley Hospital several years ago and more recently a statewide committee has been formed. Currently, Dr. Tracey Sondik and Julienne Giard are co-chairing this statewide committee. The first annual conference was held in December 2016 and a second one is planned for December 2017. There is increased emphasis in this area relative to the opioid crisis (e.g., alternative pain management strategies). A webpage was created on the DMHAS website documenting the committee's work and information on this topic:
http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=580236

Alternative treatments and initiatives targeting Wellness have become more generally accepted and are providing opportunities for clients with mental health, substance use and co-occurring conditions to empower themselves by taking control of their own recovery. Healthy activities related to diet, exercise, meditation, etc. are offered in group settings which also provide an opportunity for positive social interactions and the forming of friendships with peers. Connecticut has TOIVO in Hartford and plans to expand into another such center underway. At TOIVO, people in recovery from mental health and substance use issues operate the programs and engage others in their activities which include yoga, mindfulness and other creative activities.

In FY 2011, DMHAS created an Evidence-Based (EB) and Best Practices Governance Committee. This committee continues to meet on a quarterly basis. The Governance Group consists of executive staff and Office of the Commissioner Division Directors. In 2010, DMHAS had designated a new position in the Office of the Commissioner: Director of Evidence-Based Practices (EBPs). This position provides staff support to the Governance Group along with other functions that promote the adoption of evidence-based practices throughout the system of care. Four managers report to the Director of EBPs, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system. In 2015, this division also took on the federal grants coordination role, which

includes leading the writing and submission effort for SAMHSA discretionary grants. These grants are often a vehicle for incorporating EBPs into the system.

The EBP Division created a series of webpages on the DMHAS website that describe different EBPs and various publications available to help implement the practices. This is a valuable resource for providers, consumers and families: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912.

Targeted Services and Populations

DMHAS provides a number of specific targeted services to various adult populations in need of mental health treatment and recovery services. A brief description of those services and the targeted populations served follows:

Trauma Services

Assisting in recovery from the effects of abuse and other forms of trauma is essential to the well-being of survivors. Because recovery is integral to the DMHAS mission, the department is committed to the provision of services that are responsive to clients who are trauma survivors. DMHAS supports trauma-informed and trauma-specific services through:

- Seeking to reduce and eliminate those practices identified as having a negative or re-traumatizing effect on trauma survivors;
- Ensuring that service providers are aware and respectful of the importance of the values, traditions, and customs of the clients they serve; and
- Combating barriers to the development and provision of trauma-sensitive services for all persons engaged in DMHAS or DMHAS-funded services.

Connecticut adopted a Trauma Services Policy in April 2010, which DMHAS believes to be one of very few in the country. The purpose of this policy is to foster a behavioral health system that employs and practices principles that are trauma-sensitive and trauma-informed to individuals served by DMHAS and funded agencies. Services within this system must meet the needs of individuals and their families who have experienced trauma by establishing an environment that is safe, protects privacy and confidentiality, and eliminates the potential for re-victimization. Standardized screening tools for trauma are used and staff training is available.

DMHAS contracts annually with the Connecticut Women's Consortium to provide training and consultation on trauma-informed (TI), trauma-specific (TS), and gender-responsive (GR) services to DMHAS-operated/funded agencies in a variety of formats:

- The Consortium releases a Training Catalogue three times a year with many TI, TS and GR workshops and training events: https://indd.adobe.com/view/7f10cc72-eaf0-4e2b-af62-610f8d44a545.

Models trained on include Seeking Safety, TREM, M-TREM, Helping Women Recover, Helping Men Recover, and Beyond Trauma. Certain trauma-specific training provides a copy of the manual for each participant. DMHAS-operated facilities get two free staff training slots for each trauma event. The cost for DMHAS-funded participants is subsidized by DMHAS funding. The Consortium also collaborates with Trauma Recovery to provide EMDR training events.

- The Trauma and Gender (TAG) Agencies Project: On an annual basis, DMHAS has been releasing a Request for Qualifications (RFQ) to recruit four DMHAS-operated or -funded agencies to guide through a two-year change process to become more trauma-informed and gender-responsive. This training and technical assistance (TA) was more focused on trauma-informed care, as opposed to trauma-specific, services. A Trauma and Gender Fidelity Scale was used to assess baseline and follow-up intervals. The Consortium contracts with expert trainers and consultants to staff this project. A comprehensive written toolkit is provided to the agencies as a resource. DMHAS is in the process of revising this training and technical assistance model to include more agencies on a regional level across the state.
- The Consortium publishes a *Trauma Matters* newsletter quarterly which is widely distributed.
- The Consortium maintains a Trauma Directory of trauma services statewide. DMHAS recently completed its second statewide survey of DMHAS-operated and -funded agencies to update this directory.
- A quarterly Trauma Providers Meeting is hosted by the Consortium for networking, presentations, and sharing lessons learned in providing trauma services.
- A statewide Trauma and Gender Guide Team meets monthly which includes representation from DMHAS, the Consortium, TAG Agency Providers Project, persons in recovery, and consultants to share information, progress, and new directions.
- The DMHAS Trauma webpage: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335292.

Women's Services

In an effort to meet the many needs of pregnant women and women with dependent children with substance use disorders, DMHAS funds a number of programs established to provide comprehensive addiction services to substance using women and their infants and children.

Treatment services provided by these programs include individual, group, and family therapy, and where appropriate, family members are encouraged to participate in treatment sessions and self-help groups. The programs emphasize proper pre/post natal care in cooperation with local medical facilities. Educational and counseling groups concentrate on nutrition, hygiene, child development,

substance use prevention, coping skills, and women's issues. These programs also allow participants to improve their education through GED classes or participation in courses at the local community college.

All contracted women's specialty programs provide directly or through a referral the following services:

- Primary health care and prenatal care;
- Primary pediatric care including immunizations for children of women in treatment;
- Mental health services, including evaluation, treatment, and medication prescribing and monitoring;
- Linkages to coordinate and integrate support services with substance use services and prenatal services;
- Non-emergency transportation to medical and social services for pregnancy-related care;
- Access to voluntary Human Immunodeficiency Virus (HIV) and tuberculosis (TB) testing and counseling;
- Child care and child development services which facilitate mother-child bonding and teach/enhance parenting skills;
- Identify and provide services for children with prenatal exposure to drugs and alcohol;
- Random urine or breathalyzer testing;
- Discharge planning and aftercare, including referrals to appropriate services and supports, relapse prevention and referrals to housing; and
- Access to the following services: Vocational rehabilitation, family planning, rape crisis services, incest survivor services, domestic violence shelters, school-based health clinics, parent aid services, birth to three programs, life skills training, nutrition and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs through written cooperative agreements with other agencies.

Women's Funded Services under the Block Grant

Liberation Programs – Families in Recovery, a residential substance use treatment program for pregnant and parenting women and their children offers services that assist women to develop and maintain a substance-free lifestyle, such as relapse prevention, access to primary health care and prenatal, delivery, and post-partum care. Other services offered include life skills development, anger and stress management, parenting skills, and self-esteem building. The capacity for this residential program is ten women and ten children.

Family and Children's Agency – Project REWARD provides a flexible program for outpatient substance use and child development services. Treatment topics include, but are not limited to the following: chemical dependence, relapse prevention, HIV/AIDS prevention and management, family planning, reproductive

health, nutrition, parenting skills, self-esteem, stress management and life management skills.

CASA – Project Courage - outpatient treatment program is available to women sixteen years of age and older who have a history of chemical dependence and are pregnant or have delivered a baby within the last year. The program is divided into three treatment phases: Induction, Intensive Treatment, and Intermediate Treatment. Treatment topics include: chemical dependence, relapse prevention, HIV/AIDS prevention and management, family planning, reproductive health, nutrition, interpersonal communication, parenting skills, self-esteem, stress management and life management skills.

APT Foundation – Amethyst House is a state-of-the-art residential program for pregnant and parenting women with substance use disorders and their infants with a full range of comprehensive treatment services. In addition to primary health care, prenatal, and pregnancy-related medical care, APT Foundation provides for confidential HIV testing and transportation to medical appointments. Amethyst House has a capacity of fifteen beds.

APT Foundation -The Women's Program addresses the specific needs of women by implementing evidence-based curriculum that is gender-responsive, including trauma informed and family centered services. The Women's Program at the APT Foundation is a 34-bed residential unit. Services include individual and group counseling, family therapy, domestic violence classes, and life re-orientation seminars designed specifically for women.

The Connection, Inc. – Hallie House is a residential treatment center for pregnant and parenting women with substance use disorders. This program provides the opportunity for mothers to bring their children and continue to stay in treatment if their child is born while they are enrolled in the program. Women are admitted early in their pregnancy to minimize the impact of alcohol and other drugs on both the mother and the newborn. However, pregnant women are admitted at any stage of their pregnancy. Hallie House accommodates eight women and seven children.

The Connection, Inc. – Mothers' Retreat is a residential substance use treatment program with a state-of-the-art facility design offering the same set of services as its sister program, Hallie House. Mothers' Retreat accommodates eight women and seven children.

Community Health Resources (CHR) – New Life Center is a residential treatment program designed to provide substance use treatment services to pregnant and parenting women with accommodations for their children. Services are coordinated with the local hospital and within a continuum of community-based services within the area, such as the Birth-to-Three program. The New Life Center is located in CHR's Center of Excellence along with a Women's 30-

day intensive residential program and medication assisted treatment clinic. The New Life Center has the capacity to serve six women and eight children.

Inter-Community Recovery Center (ICRC) – Coventry House provides a secure, caring residential environment designed to build self-esteem and increase a woman's ability to adopt a substance-free lifestyle and a new role as a parent. To ensure the health of the mother and her children, ICRC provides access to primary health care, prenatal, delivery and postpartum services as well as emergency care when medically indicated. This program accommodates ten women and twelve children.

Wheeler Clinic - Lifeline – Women's Services of New Britain provides a flexible program of intensive outpatient substance use treatment and child development services. The program has a capacity to serve sixteen women. The program offers transportation, meals, and assistance in helping women move into housing.

Midwestern CT Council on Alcoholism – This agency operates an outpatient program for pregnant and parenting women and their children. Treatment services include chemical dependence, relapse prevention, HIV/AIDS prevention and management, and family health and life skills development. The program capacity is twenty women.

Wellmore – Women & Children's Program - is a residential substance use treatment program for pregnant and parenting women and their children. Similar to the other residential programs for women and children, this program offers services in a gender-specific setting that fosters substance-free lifestyles, relapse prevention, and access to primary health care for both mother and child. This program has a strong family support component and is linked to the local therapeutic shelter allowing appropriate "women's" treatment services to be provided to a larger population. The program capacity is eight women and eight children.

Since 2010, DMHAS revised its Priority Access and Interim Services protocol to improve access and ensure quality of care. While all SAPT Block Grant funded programs continued to follow the same protocol in terms of ensuring Priority Access and Interim Services for women within 48 hours of requesting treatment, the Department instituted a centralized referral line for providers to manage placement and capacity issues.

All priority access calls are routed to the centralized phone number at the Department's Administrative Service Organization's (Advanced Behavioral Health – ABH) where calls are tracked and care coordination monitored. If ABH cannot obtain timely treatment placement for the women, the DMHAS Women's Administrator and/or her designee are contacted to ensure timely access to care or to have interim services arranged. ABH produces quarterly reports that include

the number of calls received and the outcome of the request. Bringing the process of earlier identification, treatment engagement and access together in one place has enhanced the previous referral system and provides a greater level of accountability regarding priority access to care for pregnant and parenting women.

In recent years, several DMHAS initiatives designed to enhance women's services statewide have been undertaken. Through collaboration with providers, DMHAS envisions that services for women will not only be accessible and effective, but will be trauma-informed and gender-responsive. Strategies were developed with key stakeholders to improve the quality of services for women and to measure the efficacy of these changes.

The **Trauma and Gender Practice Improvement Collaborative** merges the former Trauma Collaborative with the Women's Services Practice Improvement Collaborative to include representation from DMHAS, the Connecticut Women's Consortium (CWC) and Connecticut's private nonprofit providers to promote recovery-oriented, trauma-informed, gender-responsive care. The Collaborative meets quarterly to review best practices, identify tools, share information, work with nationally-known trainers/consultants, and connect agencies. The Collaborative has worked to establish a standardized screening process to identify individuals with co-occurring disorders and their treatment needs, regardless of where the individual presents for care. *As a result of these efforts, three new programs that are co-occurring enhanced have been created not only for women, but for men as well.*

Each year, DMHAS agencies have an opportunity to apply to participate in a practice improvement collaborative, including free training and consultation from nationally-recognized experts in the field of trauma and gender-responsive services. This initiative, which initially focused only on trauma-informed care, has expanded to focus on gender-responsive care as well. Currently, there are monthly and quarterly meetings to assist participant programs to explore and utilize evidence-based best practices. To date, five of the seven specialized Women and Children's Programs completed the goal of measuring the extent to which they have developed a trauma-informed, gender-responsive care environment. The two remaining Women and Children's Programs will be evaluated during the summer of 2017. This is accomplished by visiting the program and completing the Trauma Fidelity Tool, authored by Stephanie Covington, Maxine Harris and Roger Fallot, which assesses the implementation of the five trauma-informed values (i.e. safety, choice, empowerment, collaboration and trustworthiness) for clients and staff in the program. Gender-responsiveness is gauged in terms of site selection, staff selection, program development, and program content and materials that reflect an understanding of gender-specific concerns and encourage responses that respect strengths and challenges.

Project SAFE (Substance Abuse Family Evaluation)

DCF initiated Project SAFE (Substance Abuse Family Evaluation) in 1995 as a way to connect its child protection system with the adult substance use treatment system. DMHAS joined the initiative in 1999. The initial purpose of Project SAFE was to coordinate (via an Administrative Service Organization - Advanced Behavioral Health (ABH)) intake and priority access to substance use screening, evaluation, and ambulatory treatment for substance using primary caregivers of children receiving protective services. With the addition of DMHAS, the goal expanded to effectively identify and address substance use issues and to coordinate and blend state, federal, and private resources to meet the needs of this vulnerable population. The project has been enhanced by the development and implementation of clinical models that have attempted to achieve improved show rates for substance use evaluations and treatment; improved client engagement, retention and completion of treatment; increased child safety; and improved family functioning.

The services delivered under the Project SAFE contract include:

- Statewide priority access to substance use screening, substance use evaluations, and outpatient treatment services;
- Statewide toll free line to process referrals for services to participatory providers;
- Coordinated service delivery, on a regional basis, in collaboration with the ABH Program Manager, DCF, DMHAS, and the Provider Network;
- Centralized administrative services at ABH including: intake and referral, data collection, utilization and financial reporting, and electronic claims processing, and
- Quality management activities including: utilization analysis, chart reviews, provider and client surveys, and education and training.
- The Recovery Specialist Voluntary Program (RSVP) is a service available to parents/caregivers who have a substance use disorder and have had a child removed by an Order of Temporary Custody (OTC). Recovery Specialists help create solutions with clients through case management services and recovery coaching.
- Recovery Case Management (RCM) services are available for parents/caregivers with substance use problems who are active Project SAFE referrals. This voluntary program for parents/caregivers who have open cases with the Department of Children and Families in Bridgeport, Hartford, Manchester, Middletown, New Britain, Norwalk, Norwich, and Willimantic provides recovery coaching and assistance with basic needs.

Persons are eligible for Project SAFE services if they meet the following criteria:

- Parent or primary caregiver and DCF has completed a Substance Use Screen, and suspects that a substance use problem may be affecting the ability to parent effectively; and

- Referral made by DCF Social Worker (i.e., involved in child protective services) for Project SAFE services.

Young Adult Services –

Early intervention with young adults experiencing behavioral health problems can reduce the likelihood of future disability, increase the potential for productive adulthood, and avoid life-long service costs and other adverse consequences. The Young Adult Services (YAS) division at DMHAS continues to focus on meeting the needs of youth transitioning out of the DCF system into the DMHAS adult treatment system. Young adults transferring from DCF exhibit extremely complex psychiatric issues, significant neurocognitive deficits and impairments in functional life domains. As a result, the youth being referred require services and supports that create a supportive, safe, and structured environment that allows them to learn the skills that they need in order for them to transition to a more independent living situation.

In an effort to provide these levels of care that are age and developmentally appropriate and trauma-informed, DMHAS YAS not only focuses on the clinical aspects of care, but also the practical aspect of skill development and basic needs for quality of life. In addition, YAS continues to identify programs and initiate projects to support the treatment and recovery needs of these high risk youth and young adults. YAS has also established peer mentoring and youth advisory services for youth and continues to provide training and support on the inclusion of families in the person-centered planning process as well as expanding programming that emphasizes employment skills and employment opportunities in youth businesses.

In 2009, YAS established the young parents' service program in recognition of the need to assist and inform staff and young adults on the principles of positive parenting, parent-child attachment, and the effects of trauma on children and adults. Goals of the program are to support staff and to teach young adults to make informed choices, form healthy relationships, and to learn about sexuality and parenting. The YAS parenting program provides prenatal care, labor and delivery support, and postpartum supports, in addition to in-home parenting education. By supporting the pregnant young woman during her pregnancy, the chances that she and her child will experience a healthier relationship are increased.

"Be Proud Be Responsible" (BPBR) is a new two-year prevention initiative that uses an evidence-based curriculum designed to give young people the knowledge and skills they need to reduce their risk of HIV and other sexually transmitted diseases. The course offers this sensitive material in a safe and engaging manner that young adults can relate to while it educates them about sexual behavior, risk factors, and prophylactic strategies.

Military Personnel and their Families

DMHAS' Military Support Program (MSP) was established in 2007 by Connecticut General Statute and is unique in the United States. The MSP is funded by DMHAS and operated by Advanced Behavioral Health (ABH). Each year, hundreds of service members, veterans, and their families have accessed counseling services through MSP for issues such as depression, anxiety, sleep difficulties, substance use disorders, trauma, marital/family issues, and children/adolescent struggles related to a parent's deployment. Assistance is provided in the form of information and referral to outpatient counseling for service members from Operations Enduring Freedom (OEF), Iraqi Freedom (OIF) and New Dawn (OND);National Guard/Reserve members; and their families, broadly defined to include spouses, children, siblings, parents, cousins, grandparents, and significant others. All veterans with post-9/11 military service and their family members are eligible. Counseling services are confidential and available locally.

A toll free number (866-251-2913) reaches the MSP call center operated by ABH. The call center is open weekdays from 8:30 am to 5:00 pm. The MSP will provide:

- **Outreach** through involvement in the Yellow Ribbon Reintegration Program and the Embedded Clinical Program
- **Intensive Community Case Management** to assist military members and their families with obtaining timely and appropriate services
- **Referral** to local confidential counseling services using service member's insurance plans or to other free or affordable community resources
- **Follow up** through case management until a connection with resources is established

MSP services are provided at no cost to the military member and their family. For those with private insurance, the MSP staff will access the service member's providers, formulate a list of local providers, and call the providers to ensure that they have openings and are familiar with military life issues. Follow up calls are made to ensure that service members find a good match with a counselor. For those without insurance, the MSP will provide free, intensive case management to assist the service member to access state-funded outpatient services or a provider participating in a no-fee community program such as "Give-an-hour". Service members and their families are also assisted with determining eligibility for insurance and applying for coverage.

MSP staff assesses the caller's overall needs and identify resources to meet those needs. MSP staff participates in statewide and community coordinating committees that work to identify and resolve unmet needs of service members and their families. MSP partners with the Connecticut Army National Guard

(CTARNG) Behavioral Health, National Guard Service Member and Family Support Center, Vet Centers and VA Healthcare System to maximize access to existing services.

The Embedded Clinician services of the MSP provides deployment health education to service members and their families and serves as a key point of contact for behavioral health services. Embedded Clinicians are licensed behavioral health professionals assigned to specific National Guard Units who attend one drill day a month. The Embedded Clinician program is unique in that no other state in the country established a program that embeds civilian clinicians with National Guard Units at the Company level.

DMHAS Forensics Division operates a jail diversion program for veterans in Connecticut.

Persons with Mental Illness who are Homeless

In an effort to decrease the number of homeless individuals with SMI, or with co-occurring substance use disorders, DMHAS established Homeless Outreach and Engagement Teams. These teams provide outreach, assessment, engagement, and case management services to homeless individuals. The department is a recipient of federal formula funds from Projects for Assistance in transition from Homelessness (PATH) that serves persons with SMI and dually diagnosed individuals who are homeless or at risk of becoming homeless. The Homeless Outreach Teams are scattered across the state in urban, suburban, and rural settings. In addition to these Homeless Outreach Teams, DMHAS worked to create a network of social service and rental subsidy providers to produce over 3700 units of permanent supportive housing. These units include housing subsidies with case management services and are dedicated to individuals who are experiencing homelessness and have a mental health or co-occurring substance use disorder with the goal of stabilizing the individual in the community.

Persons involved in Criminal Justice System (see Forensic Services Division)

In Connecticut, the Department of Correction (DOC) operates all jails, prisons and Adult Parole. Bail services are administered by the Court Support Services Division (CSSD) of the Judicial Branch. Law enforcement is operated by local police and state police.

While DMHAS does not provide behavioral health services in correctional facilities, it implemented all programs for criminal justice involved persons in collaboration with police, courts, DOC, probation, parole, Board of Pardons and Paroles and continues to operate the programs with these collaborations. DMHAS participates in multiple standing and ad hoc state level committees and

commissions that address criminal justice policy and programming. DMHAS chairs a monthly meeting with DOC custody, program, and mental health staff, Parole, Probation, and LMHAs to address system barriers and plan for release coordination of inmates with mental illness.

The DMHAS Division of Forensic Services manages a variety of community programs for adults where close collaboration with the criminal justice system is needed to maximize diversion and successful re-entry. Services range from the Crisis Intervention Team program for police to divert individuals at the time of initial contact with law enforcement, to an array of court-based jail diversion (JD) and specialty diversion programs in lieu of incarceration, to coordinating arrangements for continuing behavioral health care for those with an anticipated DOC release, including appointments, expedited Medicaid eligibility, identification papers, etc.

The 2011 State of Connecticut Re-entry Strategy outlines the process of connecting released inmates to community services. The plan is available at: http://www.ct.gov/opm/lib/opm/cjppd/cjcjpac/20110215_reentry_riskassessmentstrategy.pdf.

Rural/Older Adults/Nursing Homes/Medicaid Home/MFP

Persons who live in Rural Areas

The Connecticut Office of Rural Health (CT-ORH) has defined “rural” as a census of less than 10,000 **and** a population density of 500 people or less per square mile; as adopted by the CT-ORH Advisory Board November 2014. As of July 1, 2015 United States Census Population Estimates, the rural population for the state is estimated at 331,094. While 14 of the 68 rural towns saw an increase in population, the overall rural population reflects an approximate decrease of 3,181 persons. The total rural population currently represents 10.8% of the state’s overall population. Each county has some town within its borders that meet the definition of “rural”, although the vast majority of these are within the Eastern and Northwestern portions of the state.

DMHAS continues to examine the need for behavioral health services in those areas considered rural, and the accessibility and availability of such services. DMHAS’ past efforts in developing local systems of care has taken into consideration geographic differences and the impact of these differences, such as lack of public transportation on service delivery. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices.

DMHAS is represented on the CT-ORH Advisory Board and shares information about new and existing programs, funding opportunities, and collaborative efforts to enhance access to behavioral health care and services for those living in

Connecticut's rural communities. DMHAS consulted with the CT-ORH to assist with addressing challenges in providing treatment and recovery services for persons with opioid use disorders. As a result of this partnership, two agencies serving rural communities received funding to increase their capacity. DMHAS invited and the CT-ORH accepted membership on the statewide Alcohol and Drug Policy Council (ADPC) Treatment Subcommittee, bringing to the forefront the needs and issues of rural residents with regard to accessing quality behavioral health care.

Persons with Disabilities and Older Adults

In 2011, the DMHAS Commissioner issued a departmental policy statement, *Accessibility to Services, Programs, Facilities and Activities*, which outlines the requirements of facilities in regard to their responsibilities pursuant to Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. All state-operated and contracted agencies are required to meet these requirements. The policy can be found at:
http://www.ct.gov/dmhas/lib/dmhas/policies/Chapter2.20.pdf

Services for Older Adult Population

As one in four older adults has a significant mental health disorder, this population requires focused attention and resources. Older adults with mental illness are at increased risk for receiving inadequate and inappropriate care. Without adequate treatment, mental health disorders in older persons are associated with significant disability and impairment, including compromised quality of life, cognitive impairment, increased caregiver stress, disability, increased mortality and poor health outcomes. Older adults with mental health problems also have higher emergency department utilization and cost of healthcare services in general. As the baby boomer generation ages, it is estimated that by the year 2030, the number of older adults with major psychiatric illness will reach 15 million nationwide. In fact, in Connecticut, the general population is expected to increase by 9%, while the population age 65 and older is expected to increase by 35%. Proportionately, Connecticut has one of the largest older populations in the nation.

DMHAS' Long Term Services and Supports (LTSS) unit continues to broaden its statewide partnerships with providers of services to older adults. The LTSS Clinical Director attends the Office of Policy and Management's Long Term Care Planning Committee and co-chairs the Older Adult Workgroup with staff from the State Department on Aging. The Older Adult Workgroup is comprised of public and private providers of services to older adults. The Workgroup joined efforts with the University of Connecticut's Center on Aging to conduct a statewide assets mapping project to identify system strengths, needs, and service gaps. The project has been completed and results shared at the state capitol as well as disseminated to stakeholder groups throughout the state. The LTSS Clinical

Director also chairs the Older Adult Workgroup Education and Training Subcommittee. As part of that subcommittee, partners from NAMI, Department of Social Services, and McCall Foundation are working to create on-line training products focusing on older adults for providers, consumers, and caregivers.

DMHAS LTSS currently manages the Senior Outreach Program that services older adults with substance use disorders and mental health needs. Seven private nonprofit agencies in Connecticut focus on outreach and engagement of older adults who are in need of treatment, but are not receiving services. Through the process of engagement, staff refer individuals to an appropriate level of care, including a weekly age-specific support group.

Another program that assesses for appropriate level of care is the Nursing Home Diversion and Transition Program (NHDTP). Through collaboration with DMHAS-funded agencies, the NHDTP was established with two goals: (1) to divert clients from nursing home placement unless absolutely necessary; and (2) to assist clients already in nursing homes to return to the community with ongoing support services. The NHDTP Nurse Clinicians and Case Manager work in conjunction with the state's Money Follows the Person Demonstration Project, and operate, in collaboration with the Medicaid Home and Community-Based Services (HCBS) Waiver for Persons with Mental Illness. Individuals who may not meet criteria for the waiver, or may not want wrap-around waiver services, may be served by the DMHAS NHDTP.

The three programs described above: The Medicaid HCBS Mental Health Waiver, The Nursing Home Diversion and Transition Program, and The Senior Outreach Program, identify individuals who are institutionalized or at risk of being institutionalized and attempt to provide them with the least restrictive setting for long-term care.

Screening for Nursing Homes and Long-Term Care

A statewide needs assessment of Connecticut citizens regarding long-term care services found that approximately 25% of the respondents reported symptoms of depression. Additionally, persons with psychiatric disabilities reported difficulty accessing mental health services. To address these issues, the final Long-Term Care report to the General Assembly stressed the importance of state agency collaboration.

In February 2010, DSS contracted with a national vendor, ASCEND, to manage Connecticut's Pre-admission Screening Resident Review (PASRR) Program. In collaboration with DSS, DMHAS continues to work closely with ASCEND, to divert people from nursing homes and find more appropriate community placements. All clients with mental health issues are screened prior to admission to nursing homes. DMHAS receives admission data from ASCEND that enable

staff to track, treat, and discharge individuals who improve and do not continue to meet Nursing Home Level of Care.

Medicaid Home and Community-Based Services, Mental Health Waiver

In September 2008, Connecticut was approved for a Mental Health Home and Community-Based Waiver to return clients to their communities who are currently receiving services in a nursing home. This also allows clients with mental illness in nursing homes to participate in the Federal Money Follows the Person (MFP) demonstration grant. Both of these rebalancing programs started in 2009 with the goal of discharging clients from nursing homes under a cost cap. Since April 2009, under the Mental Health HCBS Waiver, approximately 1020 clients were discharged or diverted from Nursing Homes into the community with the Mental Health Waiver Supports. The unique services of the Mental Health Waiver focus on psychiatric rehabilitation and recovery. The services are designed to help clients achieve the maximum independent functioning and recovery within their communities. Since 2008 under the Nursing Home Diversion and Transition Program (NHDTP), approximately 2,994 clients have been transitioned from Nursing Homes into the community.

DMHAS service recipients have access to financial choice in self-directed care through the Mental Health Waiver. The Community Support Clinician, under contract or staffed by DMHAS, provides information to the waiver participant to support efforts to direct their own services. Individuals directing their own services are referred to the fiscal intermediary to provide employer-related services. The fiscal intermediary coordinates multiple activities related to Recovery Assistant (RA) and Overnight Recovery Assistant (ORA) services such as recruitment, maintaining a registry of service providers, providing enrollment packets, performing background checks, providing information and training materials to assist in employment and training of workers, facilitating meetings with the participant and the staff providing RA and ORA services, managing, on a monthly basis, all invoices for RA and ORA against the amount of services authorized in a participants Recovery Plan, and developing fiscal accounting and expenditure reports.

Money Follows the Person (MFP) Demonstration Grant

Both DSS (the State Medicaid Agency) and DMHAS have been involved in determining how many clients with psychiatric disorders are currently residing in Connecticut nursing homes. People eligible for DMHAS services are referred to the appropriate community provider. Through collaborative processes and in conjunction with the Mental Health Waiver and the Nursing Home Diversion and Transition Program, DMHAS and DSS MFP Demonstration Grant staff work to effectively discharge clients back into the community in a clinically sound manner. DMHAS meets with DSS (the MFP awardee) on a regular basis to identify individuals, specifically those in nursing homes, who may be eligible for

MFP and then move onto the Home and Community-Based Waiver. DMHAS is an active member of the MFP Steering Committee, which is comprised of a coalition of cross-agency staff that addresses improved discharge planning regarding entitlements, housing, and other services. DMHAS also sits on the Long-Term Care Planning Committee and is working with both University of Connecticut and DSS to define a continuum of care strategy for aging clients with chronic conditions.

Prevention Services

Prevention services are within the Office of the Commissioner and under the oversight of the Director of Prevention and Health Promotion. The Prevention & Health Promotion Division oversees and administers the prevention set-aside funds for the Behavioral Health Block Grant, the implementation of the Synar amendment, and a number of federal discretionary grants that are earmarked for specific issues. The Prevention and Health Promotion Division is strategically aligned with SAMHSA's Strategic Prevention Framework (SPF) and its five steps comprised of 1) conducting needs assessments, 2) mobilization and capacity building, 3) planning, 4) implementing evidence-based strategies, and 5) monitoring and evaluation. The division is organized to provide accountability-based, developmentally appropriate, and culturally sensitive behavioral health services based on evidence-based models and best practices, through a comprehensive system that matches services to the needs of the individuals and local communities.

The DMHAS prevention goal is to promote emotional health and reduce the likelihood of substance use and mental illness. The DMHAS prevention statewide system of services and resources are designed to provide an array of evidence-based universal, selected, and indicated programs and promote increased prevention service capacity and infrastructure improvements to address prevention gaps.

DMHAS prevention programs are organized into two major categories: (1) Direct Service Programs that focus on tobacco prevention and enforcement, underage alcohol use prevention, the prevention of non-medical use of prescription drugs and opioid overdoses, mental health promotion, and programs that link substance use, mental health and other problem prevention; and (2) The prevention infrastructure resources that undergird and support prevention service capacity and infrastructure improvements to address prevention gaps.

Governor's Prevention Partnership – is an organization comprised of public/private partnerships focused on building a strong, healthy future workforce by providing mentoring programs, violence prevention programs, underage drinking programs and other drug and alcohol programs. They also raise awareness of issues through their partnership with several media outlets across the state and nationally.

Training and Technical Assistance Services Center – provides training workshops that focus on prevention skills development, application of these skills, mental health promotion, and violence and substance use prevention. They also assess the workforce training needs and ensure that trainings align with Prevention Certification.

Center for Prevention Evaluation and Statistics (CPES) – operated through a contract with the University of Connecticut's Health Centers' Department of Community Medicine, the purpose of this center is to collect, manage, analyze and disseminate data from our prevention projects; provide training and technical assistance to the prevention field on data and evaluation related topics; and help us with the development and administration of data. The CPES also administers the ***State Epidemiological Outcomes Workgroup (SEOW)***. An interagency group of data experts, the SEOW is charged with compiling indicators or substance use and related consequences, tracking data trends over time, and promoting the use of data to continually focus and strengthen alcohol, tobacco and other drug prevention efforts statewide.

Connecticut Clearinghouse – is a statewide library and resource center for information on substance use and mental health disorders, prevention and health promotion, treatment and recovery, wellness and other related topics. In addition to this they assist with coordinating and delivering specific training and operate a listserv for Prevention. They are also instrumental in providing educational materials for the tobacco merchant education program which discourage the selling of tobacco products to minors. Lastly, they manage a statewide group of college/university personnel who have come together to address campus substance use and they administer mini-grants to these campuses.

Regional Action Councils (RACs) - thirteen public/private sub-regional planning and action councils that have responsibility for assessing needs, planning for, developing and coordinating substance use services in their respective regions. Specifically, they provide and support the use of community, regional, state, and national substance use and related mental health data to prevention providers to assess needs and gaps in services, guide planning, implementation, evaluation and continuous quality improvement. RAC membership is mandated and includes: the chief elected official, law enforcement, school personnel, treatment agencies, businesses, substance use service providers, private funders, media representatives, community representatives and state legislators. In their planning and coordination role, RACs serve as Strategic Community Partners to link state substance use prevention, mental health promotion and related priorities to local and regional initiatives. RACs also provide direction for and oversight of Local Prevention Council (LPC) contracts.

Local Prevention Councils (LPCs)- This initiative involved entitlements grants to all 169 cities/towns throughout Connecticut to support local, municipal-based alcohol, tobacco and other drug (ATOD) use prevention councils. The intent of this grant program is to facilitate the development and/or implementation of ATOD use prevention initiatives at the local level with the support of the chief elected officials. The specific goals of LPCs are to increase public awareness of ATOD prevention and stimulate the development and implementation of local prevention activities primarily focused on youth. Funds have been used to leverage more resources and can be used to support activities to increase awareness of opioid problems in this region.

Aside from direct services, the Prevention Unit continues to: 1) professionalize the field by promoting prevention certification; 2) incentivize communities to take ownership of the need to serve their members who are impacted by substances; and 3) build an infrastructure that is responsive to needs and trends in communities and across the state.

Other DMHAS Programs

HIV Early Intervention Services

Connecticut's status as an AIDS designated state has fluctuated over and under the threshold for the past several years. The most recent data available from the Centers for Disease Control and Prevention locate Connecticut's AIDS rate at 8.8 cases per 100,000 people for 2015, below the threshold. As previously when the state fell below the threshold, DMHAS will continue its HIV Early Intervention services, recognizing the importance of this service in a state with a high rate of IDUs. In addition, SAMHSA's ruling that a state may use SAPT Block Grant funds for the first year of being de-designated allows DMHAS to continue to support the full array of HIV Early Intervention Services through the SAPT Block Grant.

Since July 1, 2011, DMHAS directed those substance abuse treatment providers previously designated as "set aside" providers to implement "opt-out testing". This was based upon the Centers for Disease Control and Prevention recommendations for "opt-out testing" for HIV/AIDS and the subsequent passage of Connecticut's own revisions to the state's HIV testing consent law (effective date – July 1, 2009). If an individual does opt out, they do receive the pre-test counseling to inform them of the risks if they are HIV positive. DMHAS has heard from providers that opt-out testing has increased the numbers of people being tested. In the past, many people did not want to participate in what they considered "probing" pre-test counseling, which carried a stigma of its own, but are now more willing to be tested as part of other routine medical examinations. Providers continue to provide risk reduction counseling, family/partner support, referrals to partner notification services, nutritional counseling, and, in some

cases, alternative therapy such as acupuncture. All clients tested also receive post-test counseling services.

TB Services

In FFY 2000, DMHAS' Medical Director reissued department guidelines for state TB control policies that incorporated more effective procedures and techniques for dealing with, among other things, new drug-resistant strains of tuberculosis. These protocols included medically approved procedures for: 1) proper screening of patients; 2) identifying individuals found to be at risk of becoming infected; 3) appropriate testing of those found to be at risk; and 4) meeting all state reporting requirements while adhering to federal and state confidentiality requirements. These new guidelines were disseminated to all treatment programs throughout the state for inclusion in their infectious disease protocol.

DMHAS set-aside providers ensure that all persons admitted are informed of and offered infectious disease services, including TB screening in a timely manner. DMHAS continues to offer technical assistance as needed to treatment programs that assure appropriate identification, treatment, and/or referral for those individuals identified as infected with TB.

The HIV/TB Services Administrator monitors DMHAS providers for compliance with infectious disease protocols, which provide for the identification of affected clients. CSD Regional Teams complete randomized chart reviews as part of their routine monitoring activities.

In FY 2014 and 2015, DMHAS experienced issues around TB testing due to the shortage of testing supplies that was felt nationwide. DMHAS set-aside providers maintained efforts geared toward assessing at-risk individuals so that testing could be provided to those identified.

On October 1, 2016, DPH changed their practice of providing ppd solution for TB screening, prompted in part by very low numbers of Connecticut residents being found positive for active TB, even among populations previously considered at risk. This change aligned with CDC's efforts to revise guidelines/practices based on data that included the involvement of the Connecticut TB Control Officer, Lynn Sosa, M.D. of the Connecticut DPH. These changes affected some DMHAS providers which had been receiving ppd solution directly from DPH without charge. Since federal law requires substance use treatment programs that receive SAPT block grant funds to directly, or via arrangements with other providers, make TB services available, DMHAS also had to respond to these changes. After consulting with the Connecticut state TB Control Officer (Lynn Sosa) and the SAMHSA CSAT project officer (Lisa Creatura), a resolution was found. DMHAS will continue to screen clients, but will do so through the use of a questionnaire, as is the practice in many other states. Those clients identified as at risk by the questionnaire will have a ppd and those with a positive ppd result

will be referred for further services as indicated. Each affected program has a choice to either purchase ppd solution and conduct this screening at their facility or refer such clients to a community health center.

Following notification of the involved facilities, a meeting was held with the 9 providers (10 sites), the DMHAS HIV/TB Services Administrator, the Block Grant State Planner and the DPH TB Control Officer. The DPH TB Control Officer presented the evidence for the change based on Connecticut data, including the very small number of active cases (including among IVDU) and identified at risk groups in our state as refugees from other countries or persons exposed to such refugees.

Charitable Choice

DMHAS continues to monitor programs affected by the SAPT block grant regulation of Charitable Choice, assuring compliance through routine monitoring by CSD Regional Teams across the DMHAS service system. Monitoring of the charitable choice requirement is by exception, i.e., the CSD Regional Teams follow up on any complaints received. Beginning in State Fiscal Year (SFY) 2012, DMHAS added contract language specifying the requirements of 42 CFR Part 54 and 54a prohibiting the use of SAPT block grant funds to support inherently religious activities in treatment services. Periodically, DMHAS sends a notice to providers reminding them of the Charitable Choice requirements. In addition, faith-based providers post documents pertaining to the rights of clients to treatment services free of proselytizing and the right to seek referrals to alternative providers if the client objects to the religious nature of the provider. The department continues to explore additional options for enhancing provider awareness of the Charitable Choice regulation, especially the client's freedom not to engage in religious activities and their right to receive services from an alternative provider.

Services for the Deaf and Hard of Hearing (DHOH)

The Office of Multicultural Health Equity (OMHE) coordinates the delivery of American Sign Language (ASL) services for the deaf and hard of hearing (DHOH). As part of this work, OMHE works with selected vendors to provide interpreter services for individuals and family members who are hearing impaired within the DMHAS system of care. Video phones are installed in each of the state operated facilities that serve the DHOH population. Interpreter services are available at DMHAS providers for all types of services including evaluations; education/training; clinical activities; AA and NA meetings; and LGBT, peer and other social groups. Specialized services are also provided through an interpreter, including forensic evaluations, life skills training, job coaching, parenting education, and tutoring in ASL as well as other topics.

Office of Multicultural Health Equity (OMHE)

The Office of Multicultural Affairs (OMA) was established in 1997 to enhance the delivery of DMHAS mental health and substance use services for all individuals from diverse backgrounds, including, but not limited to, such differences as race, ethnicity, age, gender, sexual orientation, spiritual background, and physical or mental status. Key goals of the OMA were to increase cultural competence at the direct care, organizational, and system levels and to identify and eliminate disparities through increased policy, program, and system development and design.

OMA is now the Office of Multicultural Health Equity (OMHE). Our focus continues to be about the infusion of cultural competency and the identification and elimination of disparities. The current Strategic Plan from 2016 seeks to further imbed cultural competency within the DMHAS infrastructure and to enhance in-depth understanding of cultural factors and forces to analyze health disparities. Goals of the Strategic Plan include:

- Enhancing the DMHAS data collection system to include key demographic and cultural variables in all state-operated programs utilizing a new data collection tool for admissions that collects information on gender, race, ethnicity, preferred language, gender identity, sexual orientation, and vision and hearing problems
- Ensuring the implementation of Culturally and Linguistically Appropriate Services (CLAS) standards focusing on language access to be in compliance with federal law and to eliminate health disparities
- Providing training and technical assistance in implementing CLAS standards throughout the DMHAS service system
- Ensuring the diversity of member representatives on the Multicultural Advisory Council (MCAC) reflects the stakeholder groups and the continuity of MCAC work

Through the implementation of the Strategic Plan, DMHAS seeks to use linkages with other state agencies to further develop regional, cultural and recovery resources. It also provides the department opportunities to explore ways to implement cultural best and promising practices throughout the DMHAS system of services and supports, including the use of peer training for system change developed through collaboration with the Yale Program for Recovery and Community Health (PRCH).

DMHAS introduced a Connecticut Health Foundation funded initiative in collaboration with PRCH to develop and test a cultural competence system change intervention that uses consumers telling their stories to develop an understanding of the impact of bias and stigma on treatment and delivery of services. This ongoing effort, called *Recovery Speaks*, involves persons in recovery from substance use and mental health conditions sharing their success stories at different DMHAS and community sites.

DMHAS continues to work on its Health Disparities Initiative with support of its academic partners from Yale University. OMHE, in collaboration with Yale researchers, are continuing work to use both quantitative and qualitative methods to determine if the department's implementation of multicultural policies, initiatives, and expectations have impacted disparities in state-operated inpatient services, utilize findings from disparities research to inform system interventions, use findings from evaluations of OMHE training programs to determine effectiveness of the training programs, and continue dissemination of disparities work with presentations and training curricula.

DMHAS Administrative Units

Human Resources

The DMHAS Human Resource Division (HRD) is responsible for providing a full range of human resource services to approximately 3,600 bargaining unit, confidential, and managerial employees at all locations throughout the state. HRD consists of five divisions that include: Employment Services, Facility Operations; Labor Relations; Loss Prevention; Payroll and Benefits; and Information Systems (CORE Unit). The division provides quality, cost-effective, responsible and customer driven human resource services in order to support the department's mission, goals, and strategic initiatives. In particular, HRD has established goals for filling registered nurse and licensed clinical social worker positions through its recruitment and retention activities and in response to a very challenging job market, the HRD has hired an experienced clinical recruiter with a track record of hiring psychiatrists, physicians and executive level mental health professionals. In addition, other recruitment activities include hire day job fairs, career fairs, student internships and other recruitment initiatives that attract qualified and competent applicants. These activities also include marketing opportunities and partnerships with social work and nursing schools as viable recruitment sources. The upward career mobility, educational leave, tuition reimbursement, and other educational benefit programs are offered in support of current employees who wish to pursue academic degrees in nursing, and other healthcare related disciplines.

Office of Workforce Development

Through the DMHAS Office of Workforce Development, the department provides training to staff from both state operated and private non-profit agencies funded by DMHAS. Free Self-directed, web-based training offers courses on a variety of behavioral health care topics including LGBT issues, working with veterans, evidence based practices and working with diverse populations. Instructor-led trainings are also provided for staff providing addiction treatment services in addiction treatment and co-occurring disorders. The division offers multiple courses related to substance use disorder treatment related to evidence-based practices, including Cognitive Behavioral Therapy, Motivational Interviewing. The

division offers three course catalogs a year and trainings are offered for free to staff at both DMHAS state-operated and DMHAS-funded agencies.

In regard to patient confidentiality, DMHAS Compliance and Information Technology (IT) Security staff review, update, and develop self-directed web-based training, apprising employees of new laws and regulations affecting the DMHAS service system

Patient Confidentiality and Privacy

The DMHAS Compliance and Privacy Officer is appointed by the Commissioner and reports regularly the status of Compliance and Privacy Programs to the department's Compliance Steering Committee, which is comprised of members of the Commissioner's Executive Group and other key department staff. Each DMHAS facility has a designated Compliance Officer who reports to their individual facility oversight committee and/or their CEO. The Agency's Compliance and Privacy Officer's functions include:

- Overseeing the implementation of the DMHAS Compliance Plan by working with each facility and assessing risk areas;
- Analyzing the laws and regulations pertinent to the DMHAS health care environment;
- Consulting with the Attorney General' Office regarding interpretation of state and federal laws and actions, including possible infractions;
- Reviewing and establishing recommendations for new and existing policies;
- Establishing policies and procedures to comply with federal and state requirements;
- Promoting the Compliance Program through education and training;
- Ensuring that the seven elements of a Compliance Plan are addressed in each facility;
- Consulting with Human Resources on establishing goals and objectives for employees;
- Encouraging manager and employees to report fraud or other improprieties without fear of retaliation;
- Training and educating new employees and existing employees through workshops, web-based training, and seminars;
- Conducting unauthorized PHI disclosure analysis to determine breach status;
- Supporting the DMHAS facilities in privacy investigations and researching complaints; and
- Responding and documenting "Alert Line" inquiries and/or problems and issues.

The Agency Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities, including but not

limited to, patient records, billing records, contract agreements, etc. This authority allows the Agency Compliance Officer to monitor agency controls as well as detect and intervene with potential compliance issues across the DMHAS state system of care.

Evaluation, Quality Management and Improvement

The mission of the Evaluation, Quality Management and Improvement Division (EQMI) is to serve as the primary information and data resource center for DMHAS with regard to services provided and people served. WITS serves as the data system for the state-operated programs and DDaP serves as the data system for the private nonprofit programs. Together this data is maintained at the Enterprise Data Warehouse (EDW).

Major functions of EQMI include:

- Development, reporting and analysis of performance measures for services operated and funded by DMHAS
- Regular reports and analysis of DMHAS system performance, service utilization, and trends
- Development, oversight, and analysis of the DMHAS consumer survey
- Administration of Federal Block Grants
- Coordination of planning and priority setting activities

EQMI produces an array of routine reports including:

- Required federal data submissions (e.g., TEDS, URS)
- Triennial report of substance use activity in the state as required by the legislature
- An annual Consumer Satisfaction Report based on use of the MHSIP
- An Annual Statistical Report on the numbers and demographic characteristics of clients served in the DMHAS system
- Quarterly “dashboard” data at the provider and program level as well as aggregated by level of care state wide reflecting admissions, discharges, and other activities performed by that level of care demonstrating trends and comparing the data to state averages or thresholds

Most of the reports produced by EQMI are posted on the DMHAS website and can be accessed by the public. EQMI also collects, analyzes and reports on critical incidents, use of restraint and seclusion, DMHAS services by region and other data as requested or as circumstances dictate.

Research and Evaluation of Services

The DMHAS Research Division was created over two decades ago through a unique arrangement with the University of Connecticut. Research Division staff are hired through UCONN and considered faculty and professional staff at the School of Social Work, but collectively serve as a DMHAS unit. As such, the

DMHAS Research Division is a nationally recognized leader among state mental health and substance abuse agencies in services and applied research. DMHAS researchers, sometimes with partners at the University of Connecticut, Yale University, Dartmouth College, Brandeis University, Duke University, the Mount Sinai School of Medicine and others, have investigated many issues of policy relevance in the mental health and addictions fields. In addition to responding to the research needs of DMHAS and other state agencies such as the Department of Correction and the Department of Children and Families, the Research Division has received millions of dollars in federal funds to research such areas as supportive housing, homeless families, criminal justice diversion, co-occurring mental health and substance abuse disorders, consumer-operated services, trauma-informed care, mental health service quality indicators, substance abuse treatment outcomes, the needs of veterans, the concerns of young adults, and implementation science. DMHAS continues to conduct research to understand the processes underlying mental illness and addictive disorders, and to evaluate new techniques to respond to them. Research conducted in Connecticut informs decision-makers at both local and national levels about the effectiveness of treatment, prevention, and community-based interventions. Study findings are also reported in professional journals and at national conferences.

Recovery Services

The Director of Recovery Community Affairs (RCA) is appointed by the Commissioner to act as a liaison to people in recovery, their families, friends, and other allies, grassroots and statewide recovery organizations, as well as represent DMHAS in national organizations and events. This role assures meaningful contact, input, and dialogue with diverse representatives of the recovery community and plays a significant role in guiding policy decisions and strategic planning to promote a person and family centered, recovery oriented system of care. Within the purview of this role is responsibility for the development, support and expansion of community-based peer support in the state, e.g., the CT Hearing Voices Network. This role is also responsible for the management of Connecticut's peer workforce, including policy development, contract management, and project coordination, as well as collaboration with grass roots peer organizations and the Connecticut Department of Correction.

A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. As of 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) are participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical

assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons are trained in person-centered planning by Yale PRCH.

Other administrative units include Statewide Services Division (including Older Adult Services, Women's Services, Infectious Diseases, Housing and Homeless Services, Acquired Brain Injury/Traumatic Brain Injury Program, and Problem Gambling Services) as well as Information Systems Division (ISD).

DMHAS Advisory Bodies

In determining the need for mental health services and the allocation of resources, the Commissioner and her Executive Group confer with and rely upon the viewpoints and recommendations of many constituency and stakeholder groups across the state. This includes the State Board of Mental Health and Addiction Services (SBMHAS), a 40-member advisory group consisting of gubernatorial appointees, Regional Mental Health Boards (RMHBs), and substance abuse Regional Action Councils (RACs), consumers/individuals in recovery, family members, providers and advocates. Concerning matters of importance regarding the CMHS block grant, the state's Adult Behavioral Health Planning Council plays a critical role, reporting its recommendations to the SBMHAS and the Commissioner.

The five RMHBs and thirteen RACs were created by Connecticut General Statute and play a fundamental role in planning, prevention and advocacy efforts. RMHBs work with local Catchment Area Councils (CACs) to ensure grassroots involvement while RACs work in their local communities and are organized into the Connecticut Prevention Network. Through regular contact with persons in recovery, evaluations, and special studies, RMHB and RAC members monitor ongoing services and assess the need for services. Through these efforts, they identify service gaps and deficiencies. Their evaluations have resulted in DMHAS decisions to increase funding where service needs were identified, as well as to reduce or eliminate funding where programs were not effectively serving consumers. Members of RACs and RMHBs are selected to represent all constituent groups – consumers of services, family members of consumers, municipalities, private and public providers of services, including community services. RACs and RMHBs examine issues from the varied perspectives of these constituent groups. In that role, RMHBs and RACs also touch upon a variety of concerns related to behavioral health including stigma/discrimination, primary health and wellness, public safety, criminal justice, education, housing and employment.

In addition, DMHAS actively collaborates and supports a number of consumer/persons in recovery advocacy groups, e.g., Connecticut Community for Addiction Recovery (CCAR) and Advocacy Unlimited (AU).

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

2018-2019 Combined Block Grant
Behavioral Health Needs Assessment

The behavioral health needs of the state of Connecticut are based on a variety of quantitative and qualitative data sources including the National Survey on Drug Use and Health (NSDUH) 2015 (with 2013-2014 Connecticut estimates and Detailed National Tables), the Behavioral Health Barometer for Connecticut - 2015, the Department of Mental Health and Addiction Services (DMHAS) Annual Statistical Report for SFY 2016, the 2016 DMHAS Statewide Priority Setting Report, DMHAS Enterprise Data Warehouse (EDW) data, Connecticut Department of Public Health (DPH) data, data from the Connecticut Office of the Chief Medical Examiner, and US Census Data. The 2016 DMHAS Statewide Priority Setting Report includes provider and consumer surveys, stakeholder focus groups, and feedback on the service system from an assortment of others. From this data array, we are able to construct a rich descriptive summary identifying what is working well within our state as well as areas in need of improvement. Recommendations from all data sources are summarized at the end of this section.

Prevalence and Treated Prevalence

Any Mental Illness (AMI)

In SFY 2016, the DMHAS Annual Statistical Report, which reflects services provided by DMHAS funded and operated agencies, reported that more than 59,000 persons were served in mental health programs. Seventy percent of clients had a single mental health program admission. Nearly equal percentages of males and females received DMHAS mental health services. Most clients served were White/Caucasian (63%), followed by Black/African American (17%) and "Other" (14%). Twenty percent of clients served in DMHAS mental health programs were of Hispanic/Latino origin. Compared to the US Census Bureau's Quick Facts as of July 2015 for the state, Black/African American and Hispanic/Latino clients are over-represented in the treatment system while White/Caucasians are under-represented.

Any Mental Illness in the Past Year

	Persons aged 18 and older	Persons aged 18 - 25
National Estimates (2015)	17.9%	21.7%
Connecticut Estimates (2013-14)	16.4%	18.0%

The table above of NSDUH data reflects a lower percentage of any mental illness in Connecticut compared to the national estimates. The Behavioral Health Barometer – 2015 reported that an average of 214,000 adults with AMI (47.5% of all adults with AMI) per year (2010-2014) received mental health treatment/counseling within the year which was similar to but slightly higher than the average for the nation. Further, mental health consumers in Connecticut reported improved functioning from their treatment in the public mental health system in 2014 at rates that were higher than national rates.

Adolescent (12-17) data for this section was not fully available.

Serious Mental Illness (SMI)

Data from the Annual Statistical Report SFY 2016 reveals that just over half of the clients (52.4%) served in the DMHAS system qualified for an SMI diagnosis, which involved having one or more of the following: schizophrenia (including related disorders), bipolar, or major depression. As with data on AMI, figures for serious mental illness (SMI) were below national figures as well.

Serious Mental Illness in the Past Year

	Persons aged 18 and older	Persons aged 18 - 25
National Estimates (2015)	4.0%	5.0%
Connecticut Estimates (2013-14)	3.5%	4.5%

Adolescent data for this section was not fully available.

Dual Diagnosis (Both Mental Health and Substance Use)
Just over one quarter (28%) of clients treated in the DMHAS system qualified for a dual diagnosis of both an SMI diagnosis and a substance use disorder.

Depression
Connecticut residents with at least one major depressive episode (MDE) in the prior year exhibited numbers lower but similar to those found nationally.

Past year MDE

	Adolescents (12-17)	Young Adults (18-25)	Adults (18+)
National Estimates (2015)	11.4%	10.3%	6.7%
Connecticut Estimates (2013-14)	9.7%	8.4%	6.0%

Per the 2015 Behavioral Health Barometer, the figures for depression have been on the rise since 2009. For adolescents with MDE, more than half (52.3%) in Connecticut received treatment over the period from 2007 – 2014.

DMHAS' Annual Statistical Report for SFY 2016 reported 10.4% of clients diagnosed with a primary Bipolar Disorder and another 18.2% diagnosed with Major Depressive Disorder.

Suicide/Suicidal Thoughts
A frequent component of depression is suicidal thoughts/attempts. Data reported from the Connecticut DPH for 2015 described 381 suicides, four more than reported for 2014. Demographic characteristics of those completing suicide follow:

DPH: 2015 Completed Suicides

	Males	Females
Number/Percentage	281/74%	100 (26%)
Age range	13-93	15-91
Mean Age	50	48
White/Caucasian	90%	84%
Black/African American	4%	3%
Hispanic/Latino	4%	8%
Asian	2%	5%

Leading method of suicide varied by age and gender with suffocation being the leading strategy for those younger than 25, poisoning being the primary strategy for females 45 and older, and firearm use being the primary strategy for males 65+. The top three "known circumstances" related to the completed suicides across age groups were: 1) depression, 2) history of ever receiving mental health/substance abuse treatment, and 3) currently diagnosed with a mental health problem.

Past year serious thoughts of suicide

2013-2014	Adults (18+)
National estimates	3.9%
Connecticut	3.3%

In Connecticut, about 92,000 adults (3.3% of all adults) per year in 2013-2014 had serious thoughts of suicide within the prior year. Figures for Connecticut are less than the national average.

Alcohol

State fiscal year 2016 is the first year since DMHAS has been collecting data that alcohol is no longer the most frequently reported primary substance across all new admissions (both mental health and substance use). Despite having been outpaced by heroin, alcohol remains a prime substance of abuse in the state. For admissions into DMHAS substance use programs in SFY 2016, 33.9% of clients reported alcohol as their primary drug. The percentage of those 12 and older with alcohol use disorder nationally was 5.9% (NSDUH 2015) and those in Connecticut with Alcohol dependence/abuse was 6.8%. Thankfully, the trend downward of past year alcohol dependence/abuse nationally is also reflected in Connecticut since at least 2010.

For a number of years, Connecticut finds itself with elevated rates of underage alcohol use, including binge use. This is on top of a foundation of higher percentages of alcohol use in general. Perceived risk associated with binge drinking (5 or more drinks once or twice a week) among adolescents is very similar to the national average and low with 60.6% perceiving no great risk associated with such drinking.

	Current Alcohol Use		Binge Alcohol Use	
	Persons 12+	**Underage 12-20**	**Persons 12+**	**Underage 12-20**
National estimates (2015)	51.7%	20.3%	24.9%	13.4%
CT estimates (2013-14)	59.9%	26.3%	23.5%	16.2%

According to the 2015 Behavioral Health Barometer, 7.1% of persons 12 or older (or about 16,000 Connecticut residents per year from 2010-2014) received treatment for their alcohol use, which is similar to the national average. In reviewing the NSDUH 2013-2014 state data on those needing, but not receiving treatment for alcohol use in the past year, it was revealed that 2.68% of adolescents (12-17), 13.70% of young adults (18-25), and 6.93% of those 18 and older found themselves in this situation.

Arrests for Driving under the influence (DUI) continue to decline as they have over the last 16 years. For 2015, there were 8,235 DUI arrests, more than 2000 less than reported the previous year (State Justice Department and Federal Highway Administration data). As of July 1, 2015, all Connecticut residents who have their license suspended for DUI are required to install a breathalyzer (Ignition Interlock Device) on the ignition of their car.

Tobacco

Smoking is a major risk factor for cancer, as well as lung, cardiovascular and kidney diseases. While rates of cigarette smoking of the general population continue to decline, although use of e-cigarettes and

"vaping" may be on the rise, exceptionally high rates of nicotine dependence are found in behavioral health populations.

Past month Cigarette Use

	Persons 12+
National estimates (2015)	19.4%
Connecticut (2013-14)	16.9%

Consistent with the percentages currently smoking cigarettes above, slightly more adolescents in Connecticut perceived risk associated with smoking cigarettes (67.8%) than the national average (65.3%) in 2013-14.

Illicit Substances

Illicit substances include marijuana, misuse of prescription medications, heroin, cocaine and others. Connecticut adolescents continue to use illicit drugs are rates similar to but slightly higher than the national average, although the overall trend for both has been declining since 2010.

Past month Illicit Substance Use

2013-2014	Adolescents (12-17)
National estimates	9.1%
Connecticut	9.5%

When surveyed about past month use of illicit drugs *other than marijuana*, the percentages were substantially lower, indicating that marijuana use is the bulk of illicit substance use in our state.

Past month Illicit Substance Use with and without Marijuana Use in Connecticut by Age Group

Connecticut (2013-14)	12+	12-17	18-25	18+
All Illicit Substance Use	9.9%	9.5%	24.3%	10.0%
Illicit Substance Use other than Marijuana	3.1%	2.9%	6.4%	3.2%

With respect to treatment, the Annual Statistical Report FY 2016 finds that more than 61,000 persons were treated in DMHAS substance use programs, most were admitted for illicit substance use which was most frequently for heroin/opioids. The Behavioral Health Barometer 2015 reported that 20.1% of persons with Illicit Drug Dependence/Abuse received treatment every year from 2007 to 2014. Those needing but not receiving treatment for illicit substance use per the NSDUH 2013-14 data were 3.1% of adolescents, 7.6% of young adults, and 2.4% of adults.

Marijuana

Nationally and in Connecticut, marijuana is the most abused illicit substance. Of all the substances surveyed, perceived risk of marijuana use is clearly the lowest with 78.2% of Connecticut adolescents perceiving no great risk in smoking it monthly, similar to the national average. Concomitantly, use of marijuana is also on the rise, a fact that is also consistent with efforts across the country to legalize the use of marijuana for medical reasons and/or for recreational use.

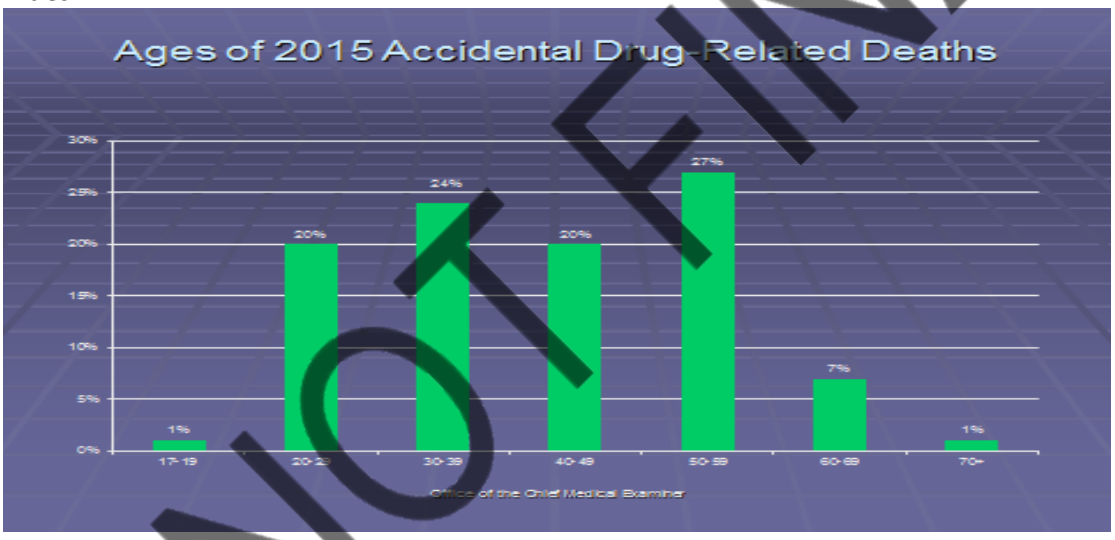
Past month marijuana use

	Adolescents (12-17)	Young Adults (18-25)	Persons 12+
National Estimates (2015)	7.0%	19.8%	8.3%
Connecticut Estimates (2013-14)	7.9%	22.4%	8.5%

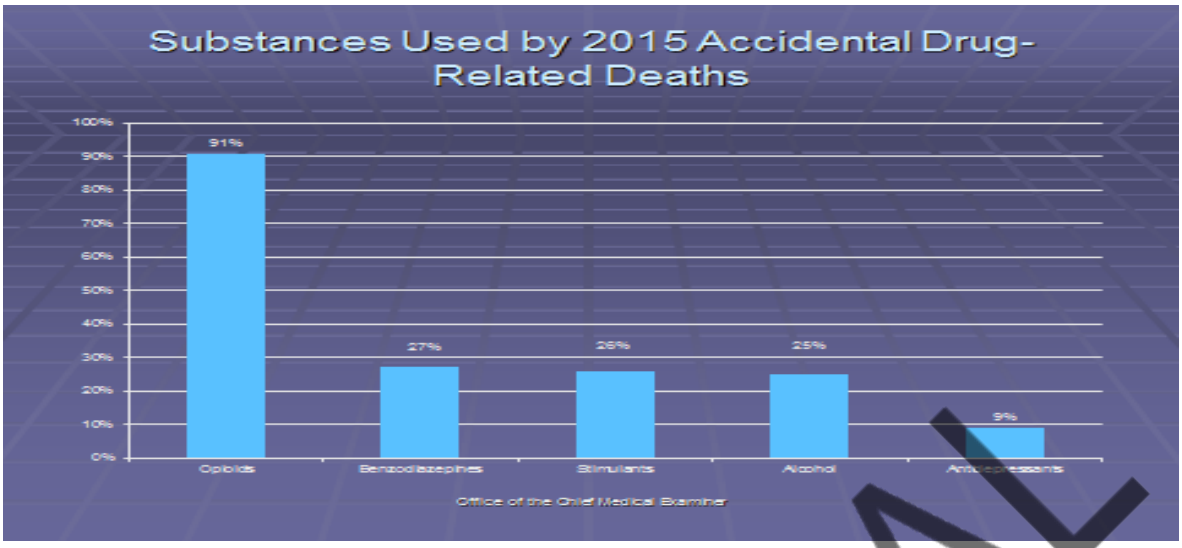
Percentages of Connecticut residents using marijuana are similar to but slightly higher than national estimates, especially for young adults.
Ten percent (4,403) of admissions to substance use programs in Connecticut for adults were for a primary dependence on marijuana/hashish/THC compared to 19% (2,070) of admissions to mental health programs. While persons entering the mental health treatment system in Connecticut were not being admitted primarily for their substance use, 19% does reflect the more widespread use of marijuana which many patients with mental health conditions seem particularly sensitive to, even in small amounts.

Heroin/Opioids

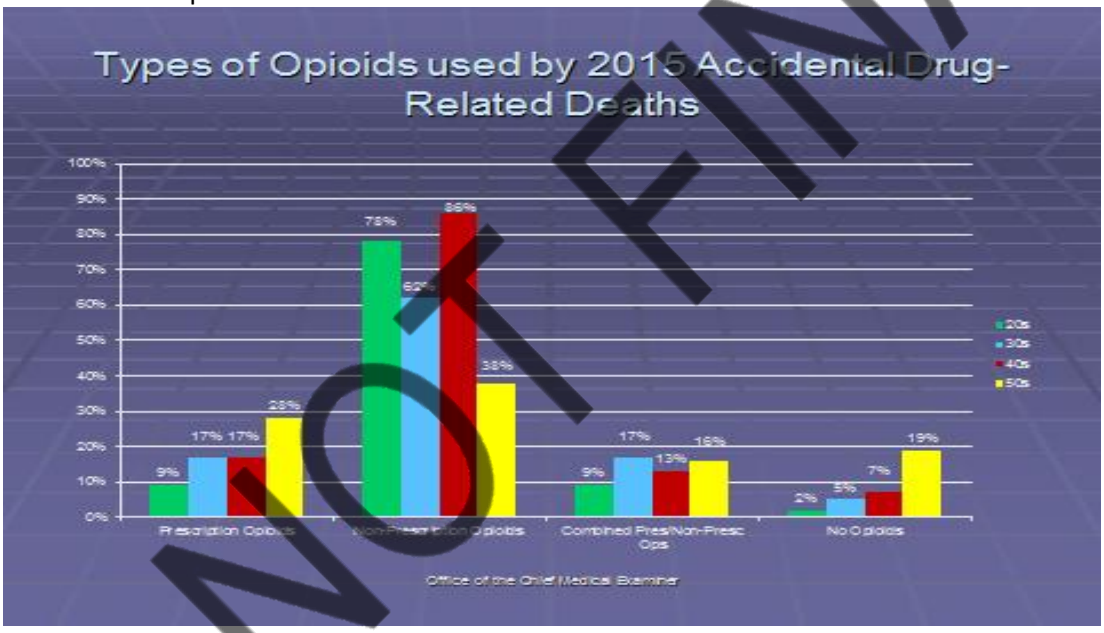
The opioid epidemic has not spared Connecticut. Every data source indicates that the problem continues, although some slight declines in prescribing and misusing *prescription* opiates is evident. An analysis of accidental drug-related deaths in Connecticut based on data from the Office of the Chief Medical Examiner (OCME) find that the numbers continue to rise every year, including 2015 which saw 723 accidental drug-related deaths. The ages of those overdosing in 2015 were from 17 – 73. Sixty percent of the overdoses involved white males and an additional 22% involved white females. The age breakdown can be seen in the chart below, reflecting that most persons who overdosed were in their fifties:



The types of substances involved in the overdoses demonstrate that most fatal overdoses involved combinations of substances and that opioid involvement is nearly universal:



Examining categories of substances involved by age reveals that while most persons involved non-prescription opioids, there was a trend as people got older, to involve prescriptions, especially opioids and benzodiazepines:

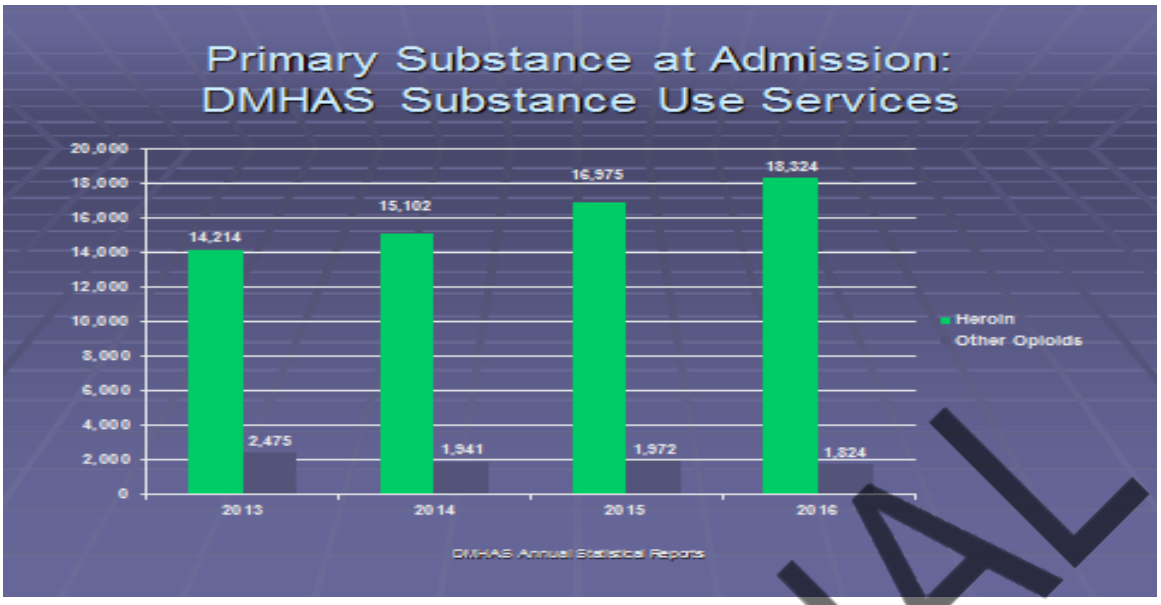


Past year nonmedical use of prescription opiates among adolescents in Connecticut has been somewhat lower, but similar to national estimates.

Past year misuse of prescription opiates

2013-2014	Adolescents (12-17)
National estimates	4.7%
Connecticut	4.1%

Most persons admitted in SFY 2016 to DMHAS substance use treatment programs were admitted for heroin (41.8%) or other opioids (4.2%). While admissions for primary misuse of prescription opiates have stabilized, admissions for primary heroin use increase each year.



Clients admitted to Medication Assisted Treatment (MAT) (methadone) during SFY 2016 numbered 6,978, while 15,736 "active" clients received MAT during the fiscal year. The number of clients prescribed suboxone (Buprenorphine) during 2015 was 25,298 per the Connecticut Department of Consumer Protection (DCP).

With respect to accessing treatment, as stated previously above, most of the admissions for substance use services in Connecticut are for heroin and the Behavioral Health Barometer 2015 indicates that 20.1% of persons needing treatment for illicit drug use received it. In SFY 2016, 18,324 persons were admitted to treatment for heroin use and another 1,824 were admitted for treatment of prescription opiates. Additionally, all active clients treated during the course of the fiscal year for heroin were 29,221 and for prescription opiates were 3,846. Undoubtedly there were other persons admitted for substance use treatment who identified another substance other than opioids as their primary substance of use who likewise received treatment. The NSDUH 2015 estimates that 0.3% of people 12 and older are past year users of heroin nationally, which in Connecticut would reflect 107,727 people. If 20.1% of these persons were to have received treatment, that would be approximately 22,623 between the numbers admitted and the number of active clients reported as treated in the last fiscal year. However, adding in the numbers provided MAT, more than 40,000; a significant effort is being made with this population. Additionally, DMHAS has made responding to the opioid epidemic its primary focus by supporting legislation that limits opioid prescriptions, requires checking the prescription monitoring system (the Connecticut Prescription Monitoring and Reporting System), makes naloxone more accessible, etc. Further, DMHAS had held public awareness/education forums around the state and provided training on naloxone use at a variety of venues, including substance use and mental health treatment providers, schools, police departments, other state agencies, etc. DMHAS also has members of its department in a variety of workgroups and committees all focused on responding to the opioid epidemic.

Cocaine/Crack

National estimates for past month cocaine use are low across age groups and few people in Connecticut were admitted for a primary cocaine problem in SFY 2016 (2,569 or 5.8% of admissions to substance use treatment). Cocaine was implicated in about a quarter of fatal overdoses involving opioids. Comparing

admissions to the previous fiscal year in which 7% identified cocaine as their primary substance, this represents a decrease of over 1%.

Persons Served in DMHAS Programs

The following data is from the 2016 Annual Statistical Report available at:
http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2016.pdf

During SFY 2016 (July 1, 2015 – June 30, 2016), DMHAS served a total of 112,864 people; 61,341 were treated in substance use programs and 59,225 were treated in mental health programs. A smaller group of 7,702 received services from both mental health and substance use treatment services. An almost equal number of males and females received mental health services, while more males than females participated in substance use services with a ratio of 2/3 to 1/3. Most clients were white/Caucasian (64%), followed by "other" at 20% and black/African American (16%).Twenty percent of DMHAS clients were of Hispanic/Latino ethnicity, with most of this 20% being of Puerto Rican origin (12%). Younger clients were more likely to receive substance use services (average age=38.1 years) while older clients were more likely to receive mental health services (average age=45.2 years). More than 90% of clients in both sets of services participated in outpatient services, followed by residential (5% of mental health clients and 19% of substance use clients) and finally inpatient (2% of mental health clients and 4% of substance use clients). Obviously some clients received multiple services during the course of the fiscal year. Young adult services (YAS) serve clients age 18 – 25 with a history of involvement in the Department of Children and Families (DCF) and major mental health problems. Of the DMHAS population age 18 – 25 treated during the fiscal year, 7.5% or 1,225 received specialized YAS services, representing a 3.5% increase over the previous fiscal year.

Drug disorders (36%) were the most frequently diagnosed condition among those receiving services from DMHAS. The largest mental health category diagnosed outside of substances was major depression (18.2%), followed by schizophrenia (12.5%) and bipolar disorder (10.4%). When looking at primary and non-primary diagnoses, just over half of the clients qualify for an SMI (serious mental illness) diagnosis, which involved having at least one of the following: schizophrenia (and related disorders), bipolar disorder or major depression. Two out of three clients (68%) have a substance use disorder. Just over one quarter (28%) of clients qualify for a dual diagnosis, meaning that they have both an SMI diagnosis and a substance use diagnosis. Post-Traumatic Stress Disorder (PTSD) is not included in the SMI count. There were 3,211 clients who had a PTSD diagnosis on record.

Among admissions to substance use programs, heroin was the most frequently reported substance (42%), and when combined with other opioids (4%), reached 46%. Alcohol was the primary drug for 34% of substance use admissions. Among admissions to mental health programs, alcohol and heroin tied for first place a 35% each, followed by 12% for marijuana/hashish/THC.

Demographics of Clients Served

	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
Gender								
Female	16,321	30.4%	26,425	51.3%	3,063	39.8%	45,809	40.6%
Male	36,776	68.6%	25,050	48.6%	4,632	60.1%	66,458	58.9%
Transgender	0	0.0%	8	0.0%	2	0.0%	10	0.0%
Unknown	542	1.0%	40	0.1%	5	0.1%	587	0.5%
Total	53,639	100.0%	51,523	100%	7,702	100.0%	112,864	100.0%

	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
Race								
American Indian/Alaska Native	236	0.4%	291	0.6%	33	0.4%	560	0.5%
Asian	390	0.7%	556	1.1%	30	0.4%	976	0.9%
Black/African American	7,281	13.6%	8,964	17.4%	1,467	19.0%	17,712	15.7%
Native Hawaiian/Pacific Islander	98	0.2%	129	0.3%	13	0.2%	240	0.2%
White/Caucasian	35,126	65.5%	32,273	62.6%	4,832	62.7%	72,231	64.0%
More than one Race	733	1.4%	213	0.4%	58	0.8%	1,004	0.9%
Unknown	2,024	3.8%	2,065	4.0%	148	1.9%	4,237	3.8%
Other	7,751	14.5%	7,032	13.6%	1,121	14.6%	15,904	14.1%
Total	53,639	100.0%	51,523	100%	7,702	100.0%	112,864	100.0%

	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
Ethnicity								
Hispanic-Cuban	156	0.3%	97	0.2%	18	0.2%	271	0.2%
Hispanic-Mexican	415	0.8%	271	0.5%	27	0.4%	713	0.6%
Hispanic-Other	4,195	7.8%	4,157	8.1%	584	7.6%	8,936	7.9%
Hispanic-Puerto Rican	6,688	12.5%	5,537	10.7%	953	12.4%	13,178	11.7%
All Hispanics	11,454	21.4%	10,062	19.5%	1,582	20.6%	23,098	20.4%
Non-Hispanics	38,068	71.0%	38,403	74.5%	5,778	75.0%	82,249	72.9%
Unknown	4,117	7.7%	3,058	5.9%	342	4.4%	7,517	6.7%
Total	53,639	100.0%	51,523	100%	7,702	100.0%	112,864	100.0%

	Substance Use		Mental Health		Both		Total	
	N	%	N	%	N	%	N	%
Age								
18 - 25	9,274	17.3%	6,124	11.9%	806	10.5%	16,204	14.4%
26 - 34	15,612	29.1%	8,426	16.4%	1,956	25.4%	25,994	23.0%
35 - 44	10,993	20.5%	8,506	16.5%	1,689	21.9%	21,188	18.8%
45 - 54	9,991	18.6%	12,105	23.5%	2,064	26.8%	24,160	21.4%
55 - 64	5,583	10.4%	11,074	21.5%	1,063	13.8%	17,720	15.7%
65+	1,244	2.3%	4,762	9.2%	123	1.6%	6,129	5.4%
Unknown	942	1.8%	526	1.0%	1	0.0%	1,469	1.3%
Total	53,639	100.0%	51,523	100%	7,702	100.0%	112,864	100.0%

Workforce Development and Shortages

Information from the Health Resources and Services Administration (HRSA) as of September 30, 2016 on Designated Health Professional Shortage Areas (HPSAs) identified a shortage of 93mental health care practitioners in Connecticut. This is more than double the number of mental health care professionals reported as needed in the previous submission based on 2012 data which identified the need as 38 practitioners. Clearly the situation has worsened. Many factors contribute to this situation, an aging mental health workforce, an aging population, and expansion of Medicaid and the ACA which increased the number of persons eligible to seek mental health treatment.

On the other hand, the designation of mental health care Health Professional Shortage Areas as of September 30, 2016 totaled only 29, including medically underserved areas (MUA: 17) and medically underserved populations (MUP: 10) and 2 Governor's exceptions (New Haven and Windham) for the state, substantially less than the 106 identified in 2012. The most populated counties had the most designations.

CT County	Total number of MUA/P in the county	Medically Underserved Areas/Populations (MUA/P)
New Haven	8	6 MUA: New Haven service area
		1 MUA: Central Waterbury service area
		1 MUP: Low income West Haven service area
Hartford	7	4 MUA: Hartford service area
		1 MUA: Central Bristol service area
		1 MUP: Low income North Branford service area
		1 MUP: Low income East Hartford service area
Fairfield	6	3 MUA: Fairfield service area
		1 MUP: Low income Danbury service area
		1 MUP: Low income West Stratford service area
		1 MUP: Low income Norwalk service area
New London	3	2 MUA: New London service area
		1 MUP: Low income Norwich service area
Windham	2	1 MUA: Windham service area
		1 MUP: Low income Southeast Windham service area
Tolland	1	1 MUP: Low income Rockville service area
Litchfield	1	1 MUP: Low income Central Torrington service area
Middlesex	1	1 MUA: Middlesex service area

The Connecticut Allied Health Workforce Policy Board of the Connecticut Department of Labor described in their January 2015 report that demand for RNs and LPNs were expected to be met in Connecticut by existing graduation rates. They identified primary care physicians as having the greatest unmet demand among health professionals, but suggested that the number of Nurse Practitioners and Physicians' Assistants would grow rapidly and could mitigate the projected shortage of physicians if utilized effectively. Several Connecticut colleges/universities now offer programs preparing graduates for health and behavioral health careers. ACCESS Mental Health Connecticut (Access to all of Connecticut's Children of Every Socioeconomic Status) is a new initiative with the goal of improving access to treatment for children with behavioral health needs while promoting productive relationships between primary care and child psychiatry. ACCESS mental health CT is designed to support primary care physicians by offering phone consultations, including education on assessment, treatment, and access to community resources for youth.

2016 Statewide Priority Setting Report

Priority Setting Process:

DMHAS' priority setting initiative, designed to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state, began in December 2001. Fundamental to this process are Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) which are statutorily charged to determine local and regional needs and service gaps. Both of these entities, working collaboratively, facilitate a process in each of the five DMHAS regions to assess the priority unmet service and recovery support needs across the mental health and addiction service systems. Since inception in 2006, DMHAS has conducted its priority setting process every other year (in even-numbered years). In the intervening years (odd-numbered years), the RMHBs and RACs provide updates to inform DMHAS of progress made in addressing the identified unmet needs and to alert the department to any emerging issues. As part of this process, RMHBs and RACs use aggregate profile data provided by DMHAS to describe usage of services within their region, provider survey results based on an on-line survey asking for responses about the DMHAS service system, and other sources of information from local needs assessments/surveys and activities. Armed with this information, RMHBs and RACs orchestrate key informant constituency groups (consumers/persons in recovery, family members, providers, referral agencies such as shelters and criminal justice representatives, and local professionals, law enforcement, and town officials) to participate in community conversations, focus groups, and/or structured interview sessions asking about service system barriers, gaps, and concerns. This process results in Regional Priority Reports across the behavioral health continuum. These reports are presented to DMHAS leadership at regional meetings, providing an opportunity for dialogue between the department and regional stakeholders. From the regional reports, a synthesized statewide priority report is created that examines cross regional priorities and solutions. The statewide report is shared and discussed with the Adult State Behavioral Health Planning Council and the Commissioner. DMHAS is indebted to the RMHBs and RACs for their ongoing efforts on behalf of the behavioral health needs of the citizens of Connecticut. Their passion and commitment are evident as they continuously strive to better the lives of persons living with mental health and substance use conditions.

It should be noted that some of the concerns identified in this report exist outside of DMHAS' purview. Matters related to other state agencies or private entities are duly noted, but will not be addressed by DMHAS. Other issues, such as transportation or housing concerns, while beyond DMHAS' ability to manage independently, are topics related to larger behavioral health issues statewide which DMHAS attempts to address jointly in ongoing efforts with other state agencies. Further, there are federal regulations governing the use of block grant funds within which DMHAS must operate. A new feature of this report is the inclusion of DMHAS activities related to identified areas of concern. While

there may not be a response for every concern raised, in many instances there are activities ongoing or planned which the reader of the report may have been unaware of.

State Profile of Services:

The number of unduplicated clients served in FY 2016 was 112,864 comprised of 61,341 clients treated in substance use services and 59,225 clients treated in mental health services (including 7,702 clients receiving both). The greatest numbers of clients served came from the most populated regions. There were 107,212 admissions, 60,703 for substance use and 46,509 for mental health. To access the Annual Statistical Report: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2016.pdf.

Demographics of DMHAS clients SFY 2016

	Substance Use	Mental Health	Total
Female	30.4%	51.3%	40.6%
Male	68.6%	48.6%	58.9%
White/Caucasian	65.5%	62.6%	64.0%
Black/African American	13.6%	17.4%	15.7%
Other or missing race	21.0%	20.0%	20.5%
Hispanic/Latino	21.4%	19.5%	20.4%
Non-Hispanic	71.0%	74.5%	72.9%
Unknown ethnicity	7.7%	5.9%	6.7%
18 - 25	17.3%	11.9%	14.4%
26 - 34	29.1%	16.4%	23.0%
35 - 44	20.5%	16.5%	18.8%
45 - 54	18.6%	23.5%	21.4%
55 - 64	10.4%	21.5%	15.7%
65+	2.3%	9.2%	5.4%
Unknown age	1.8%	1.0%	1.3%

While males and females are almost evenly divided in mental health services, in substance use programs, two-thirds of the clients are male. Most clients served in the DMHAS system are white/Caucasian (64%) while the July 1, 2015 census data finds that 81% of Connecticut residents are white/Caucasian. Ostensibly it appears that white/Caucasian clients are underrepresented and black/African American clients are overrepresented in the DMHAS treatment population; however, the category “other or missing race” is sufficiently large to caution against such a conclusion. Similarly, Hispanic/Latino clients comprise 15.4% of Connecticut’s population based on census data and are 20.4% of the DMHAS treatment population. Finally, as to age, clients in substance use services tend to be younger than clients receiving mental health services.

For clients receiving mental health services, the primary diagnostic categories are major depression (18.2%), schizophrenic disorder (12.5%), and bipolar disorder (10.4%). When examining primary and non-primary diagnoses, just over half of the clients qualify for an SMI (Serious mental illness) diagnosis, which involves having one or more of the following: schizophrenia (and related disorders), bipolar disorder, and/or major depression. It is interesting to note that two out of three (68%) of all clients (mental health and substance use) have a substance use diagnosis. This is the first year in which heroin has been reported more frequently than alcohol across total new admissions. For

clients admitted to substance use services, primary drug use was reported as heroin/other opioids (46.0%) followed by alcohol (33.9%) and marijuana (10.0%).

Most clients in both systems of care participated in outpatient treatment, followed by residential and then inpatient, as can be seen from the table below.

Levels of Care	Substance Use	Mental Health
Outpatient	55,256	58,387
Residential	11,323	2,922
Inpatient	2,717	1,428

With respect to young adults in SFY 2016, DMHAS Young Adult Services (YAS) served 1,225 clients, which represents 7.5% of the total 18 – 25 year old population served by DMHAS (16,235) and reflects a 3.5% increase over the number served in YAS in SFY 2015. YAS serves clients aged 18 – 25 with a history of DCF involvement and major mental health problems.

Structure for Evaluation:

As budgets were tightening, each state agency was required to identify their core functions so a prioritization process with respect to what would be funded could be established. The result of DMHAS' efforts to consolidate its many and varied services into a handful of categories produced the following:

	Inpatient	Outpatient	Residential; Crisis & Respite	Recovery Support Services	Education; Research & Prevention
Mental Health	Psychiatric Forensic Enhanced Security	PHP, IOP, Forensic community, ACT, Case Management, Care Coordination, BHH, Outreach & Engagement, Community Support	Group homes, Transitional, Sub-acute, Mobile Crisis, CIT, Respite, Intensive Residential	Housing/Housing Supports, Supportive Housing, Supervised apartments, Peer Services, Advocacy, Social & Vocational Rehab, Supported Employment & Transportation	Supported Education, Staff Training, Suicide & Violence Prevention
Substance Use	Medically managed & monitored detoxification	IOP, MAT, Ambulatory detoxification, Case Management & Community Support	Intensive, Inter-mediate & Long-term Residential & Halfway Houses	Recovery Houses, Peer Services, Advocacy	Staff Training, Tobacco Retailer Compliance, Violence Prevention , Substance Use Prevention

The biannual priority setting process created a grid to assist in the prioritization process within each region which utilized the 5 core functions identified by DMHAS found in the table above. Based on the various surveys and focus groups held across the state, each region established overarching issues, strengths, top 3 priorities, system gaps/barriers, and emerging issues as well as recommendations. The report which follows covers all these elements, although system gaps/barriers and recommendations are embedded within the topic areas rather than separated out. Again, as noted above, some concerns/recommendations are outside DMHAS' purview/mission or require funds which either may

not currently be available or may not be permitted by regulations associated with the federal block grant. DMHAS applauds the efforts of the RMHBs and RACs in their priority setting process, but does not necessarily endorse every finding/recommendation which follows.

Overarching Issues

There was widespread concern about the state's budget and the as yet unknown total impact of cuts of services for persons with behavioral health issues. Even prior to the most recent budget reductions, capacity concerns across levels of care were expressed. Individuals with behavioral health issues sometimes end up in an inappropriate level of care due to a lack of availability at the appropriate level causing a cascade of capacity issues and a system without an adequate flow of clients to meet the demand. Repercussions of current and possibly future additional cuts are expected to make accessing appropriate care even more challenging; lengthening already long waits, reducing already reduced services, and costing the state more in the long run due to more expensive emergency/crisis situations resulting from lack of timely medication management, psychiatric and substance use assessment, and access to the appropriate level of care when indicated. Access to limited treatments slots is further compounded by perennial basic needs challenges, especially housing and transportation. *DMHAS Activities on this issue: Over the years, during times of budget shortfalls, DMHAS' top priority has always been the maintenance of treatment services. Shortfalls are always applied to non-service related areas first.*

The lack of safe affordable housing contributes to homelessness which results in transient persons not receiving services and being at increased risk for adverse events of all kinds. These individuals are more likely to end up in Emergency Departments (EDs). Despite progress in reducing *chronic* homelessness, those who are more *recently* homeless appear unlikely to get services and providers accuse the Coordinated Access Network (CAN) of being an unfunded mandate that has shifted the homeless from shelters to EDs. Supportive housing can prevent homelessness, promote self-sufficiency, and reduce use of more expensive levels of care. Adequate rental subsidies and support services are needed to provide stability and prevent re-institutionalization. Likewise, sober housing, which can vary dramatically in quality, requires more oversight, licensing, training, and support. "Mixed" housing was viewed as problematic given the different needs of the populations in need, such as older compared to younger adults. *DMHAS Activities on this issue: The 8 CANs in Connecticut are a federal Department of Housing and Urban Development requirement which have resulted in approximately 400 new federal housing subsidies being awarded in 2015 and 2016. Targeting chronic homelessness - the most severe and costly form of homelessness - doesn't end all homelessness as it is a dynamic problem. The Partnership for Strong Communities, through the Reaching Home Campaign, has developed workgroups to address all types of homelessness, including chronic, short-term, Veterans, youth and family. Related to sober housing, Supported Recovery Housing Services (SRHS) are defined as non-clinical, clean, safe, drug and alcohol-free transitional living environment with on-site case management services available. DMHAS's agent, Advanced Behavioral Health, Inc. (ABH) credentials SRHS providers, and contracts with them, to provide housing and case management services to people in recovery. ABH currently contracts with 14 Supported Recovery Housing Service Providers with a total of 48 locations and 208 beds (male/female). Providers may have additional beds not contracted under BHRP, as self-pay beds.*

Lack of transportation is particularly problematic in the more rural areas of the state (Eastern and Northwestern) where there are fewer services to begin with, an argument for greater use of telemedicine or a mobile service that comes to the person. Problems related to Logisticare cite rude drivers and extensive waits which at times result in clients missing/late for appointments and being penalized by the provider. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which*

contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.

Across inpatient, hospital and correctional settings there was concern not only that people are discharged prematurely without being sufficiently stabilized, but also that inadequate discharge planning and follow up are contributing to recidivism, re-institutionalization, and even suicide shortly after release. While medications may be managed while the person is in the inpatient setting, longer-term wraparound supports are needed for the client and their family to increase the odds of a sustained recovery. Family members of a person with behavioral health issues need support and assistance with keeping their family intact. More follow up is needed to make sure that persons discharged get connected to the next level of care. *DMHAS Activities on this issue*: *There are emerging initiatives between Department of Correction (DOC) and DMHAS outpatient substance abuse services to ensure better connections to care for persons pre-release from DOC. These efforts are an extension of such programs operating in Bridgeport and New Haven that will now be expanded to Hartford.*

Opioid Epidemic

The structure of the priority setting process in 2016 was based on large service categories and did not lend itself to organizing around topics like the opioid epidemic; however, given the scale of the problem it is being separately addressed. Admissions rates for persons with a primary diagnosis of heroin continue to climb, as, unfortunately, do the number of opioid-involved overdoses across the state. Often the overdoses occur within a few weeks of release from hospitals, prisons, and other institutions due to a decrease in tolerance to the substance caused by a break in use. Some concern was expressed about an apparent emphasis on methadone in response to the opioid epidemic. Other treatment options are, of course, available at DMHAS programs, but medication assisted treatment (MAT) is an evidence-based practice proven to decrease illicit drug use, criminal activity, and infections. The suggestion to allow Advanced Practice Registered Nurses to be able to prescribe Suboxone and thereby further expand access to this medication has been accomplished by federal law via the Comprehensive Addiction Recovery Act (CARA 2016). Safe disposal of unused and expired medications has received much attention as about 75 police station lobbies across the state now have medication drop boxes, however, it's been suggested that more convenient drop box locations are needed outside of police stations for those who are uncomfortable with this location or have difficulty accessing it due to age or disability. The new DMHAS call line meant to assist those with opioid use disorders to access services was commented on during the priority setting process with the feedback that some callers had been told the number was only for persons using certain substances, not all substances, and only for those in need of detoxification. Those needing other services were advised to call 211. The 211 call number has also received comment, including that most people lack awareness of this service and that the 211 system needs more staffing and more training, including in customer service skills. *DMHAS Activities on this issue: This topic has resulted in positive cross agency and community stakeholder collaborations. Significant resources have been dedicated to raising awareness and educating the public via community forums and public service announcements. Expansion of (MAT) through methadone clinics and suboxone prescribing are underway and more is expected as DMHAS received a SAMHSA grant for this purpose. Training on Naloxone for opioid overdose reversals is ongoing with clinicians, administrators, police officers, school personnel, and other organizations and community members.*

Strengths

Responding to Current Conditions:

Much positive legislative activity has occurred related to current crises situations. Related to the opioid epidemic, reestablishing the Alcohol and Drug Policy Council (ADPC), establishing a 7-day limit on prescribing of opioids, raising the capacity for physicians with the DATA waiver to prescribe

buprenorphine, medication drop boxes for safe disposing of prescription medications, more first responders armed with naloxone, RAC funding, and pending agreements to place recovery coaches/crisis workers in EDs are all underway.

Mental health clients in crisis have the benefit of staff expertise and services that continue to become more integrated. Local Mental Health Authorities (LMHAs), working with law enforcement, other emergency responders, and town personnel continue to coordinate to serve those in need. Both Crisis Intervention Training (CIT) for police and Mental Health First Aid (MHFA) training for community members continue to be offered and seem to be making a difference in terms of greater understanding and recognition of common behavioral health crises. In response to barriers in accessing timely mental health services, some programs now offer same day or next day access.

Integration Efforts:

Community Care Teams (CCTs) have been developed in many locales and are targeting frequent ED users/Inpatient admissions and assisting those clients with wraparound services which address the wellness of the whole person. It was suggested that the cost savings realized from the activities of the CCT should be sufficient to fund a navigator for each CCT. It was recommended that there be coordination amongst the existing CCTs to ensure consistency of services provided.

Behavioral Health Homes (BHHs) are serving those with complex medical needs by either establishing medical clinics onsite or establishing a close working relationship with a nearby hospital for medical services. Some providers have become certified Federally Qualified Health Centers (FQHCs).

Greater awareness and collaboration between behavioral health and law enforcement providers is benefitting both systems and has resulted in more training and greater familiarity of mental health and substance use initiatives.

Homelessness:

Coordinated Access Network (CAN) has made progress toward ending chronic homelessness and there are two supportive housing options in Manchester described as “stellar”.

Wellness:

The concept of treating the whole person known as “wellness” continues to gain momentum. To a certain extent, dissatisfaction with the existing system (including instances of doctors not listening to clients or minimizing their medical issues or focusing only on medication) has been the impetus to the rise of the wellness phenomenon in which clients are empowered and the focus is on meeting their own needs. This is consistent with recommendations to teach clients self-awareness and self-care and having them develop skills rather than having providers do it for them. The need for less focus on diagnosis and more on providing alternatives and actual help, as was noted from the respondents, captures this. Involving more people in the wellness movement as a prevention effort was recommended because of its increased client participation and cost-effectiveness. This would include mindfulness, art and self-expression activities. Others propose having actual tutoring in math and writing skills. The TOIVO program offers education, support groups and alternative approaches to healing and wellness. The In Shape program, which focuses on exercise and nutrition, uses positive reinforcement with participants and is successfully reducing stress and anxiety. Some clubhouses are offering activities and groups that people want to participate in, like smoking cessation, yoga, healthy eating, and spirituality, and in an environment where those participating also develop friendships. Another provider has incorporated skill building, wellness groups and activities that are also drawing people in that might not otherwise be interested.

Recovery Supports:

Connecticut has invested in training certified Recovery Support Specialists through Advocacy Unlimited (AU) and Recovery Coaches through Connecticut Community for Addiction Recovery (CCAR). Many are working in the system, providing support for socializing, recreation, self-advocacy, employment, and community living skills.

DMHAS and its providers are committed to recovery support services, including services provided by CCAR (Recovery Coaching training, telephone support, and volunteer opportunities). Clubhouses and social programs are helping people develop relationships and success in the community by assisting them with education and training, support, activities, and stress reduction.

Top 3 Priorities

#1- Outpatient Services:

Outpatient services were of greatest concern statewide due primarily to limited access/capacity. Some programs have closed due to budget reductions or financial losses associated with insufficient Medicaid reimbursement amounts. The other barriers identified were a shortage of psychiatrists/prescribers and, of those practicing, many not accepting public insurance, including Medicaid. This situation is characterized by extended waits for outpatient appointments and larger caseloads for outpatient personnel. In response to the situation, some outpatient providers, rather than close, have cut back on services and hours, including replacing individual with group sessions, focusing on medication management rather than client skill development, and eliminating the possibilities of any extended service hours or bilingual staff. On the other hand, some providers have opted to attempt a same day access model, which was applauded by respondents and considered worth attaching incentives to.

More provision of services by case managers, CSP and ACT providers and other support services were recommended not just to assist targeted clients in maintaining treatment gains, but to make available to the overall population. Likewise, Outreach & Engagement, which is also part of the "Outpatient" category, were recommended for those in transition between different levels of care (including release from prison to community), persons who drop out of treatment, those in crisis, persons without transportation, persons with substance use disorders, seniors with behavioral health issues, and homeless persons. A number of participants felt they weren't adequately informed of all the outpatient services that were available to them, including peer supports. There was also the mention of having navigators available to assist clients with identifying and accessing resources. <u>*DMHAS Activities on this issue*</u>: *DMHAS just completed a redesign of residential support services and converted many programs to Community Support Programs (CSPs) to provide better standardization of services. There are now 28 agencies and 39 distinct CSP programs available.*

For persons with substance use disorders, accessing suboxone providers for opioid replacement therapy (ORT) has been a challenge given federal limits on the number of persons a prescriber can have on their caseload. The Department of Health and Human Services (DHHS) has recently expanded this capacity which should make this care more accessible. It was also reported that Ambulatory Detox is an underutilized level of care that more people could access. <u>*DMHAS Activities on this issue*</u>: *DMHAS was awarded a grant for high risk communities to expand access to Buprenorphine. The communities of Torrington, Bristol/New Britain, and Willimantic/Windham will not only receive funds to support expansion of Buprenorphine treatment but will also be able to hire a recovery coach at each site to assist in the process.*

The nationwide shortage of psychiatrists will not be resolved quickly given they are an aging profession with many working only part time.

#2-Inpatient Services:

Extended waits to access inpatient beds were reported with many persons occupying general hospital beds/"boarding" in EDs for the interim. The hospitals believe they are seeing more clients coming to them with behavioral health concerns. It was reported that it is particularly challenging to access inpatient beds for clients with co-occurring conditions and that community inpatient programs are reluctant to accept these more complicated co-occurring clients, preferring to leave such clients to state-operated programs like Connecticut Valley Hospital (CVH). One recommendation in this regard is to shift designation of some inpatient beds to be strictly for co-occurring clients.

For clients with substance use disorders, it's reported that accessing an inpatient bed is difficult unless the person is referred through the court/criminal justice system. Complaints about persons needing to be "high" at the time of admission screening or that they need to "fail" at a lower level of care to be admitted suggest that improper use of the American Society of Addiction Medicine (ASAM) admission criteria is occurring. Other unnecessary barriers include programs refusing persons prescribed psychotropics or certain arbitrary dosages of methadone. Complaints about insurance company barriers included dictating treatment options and caps on number of treatment episodes.

Mental health clients at CVH were reported to not be receiving sufficient therapeutic groups, adequate visitation opportunities or sufficient coordination with lower levels of care (LOCs) and housing options.

Across all inpatient settings there was concern that people are discharged prematurely – staying only long enough to have their medications managed, but not long enough to be stabilized and to acquire the skills needed to be successful at discharge. Better discharge planning/aftercare arrangements are needed including longer-term transitional wraparound supports for the whole family, in order to increase the chances for a sustained recovery. <u>*DMHAS Activities on this issue*</u>: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

#3a- Workforce:

The first priority that was part of a 3-way tie for third most important is workforce. The state-operated system has been affected by layoffs which result in "bumping" per union contract. Impacts of this "bumping" include disruption for services and clients, including potential loss of a particular expertise/specialty.

At the private non-profits (PNPs), those providing direct services to clients are described as the "working poor", unless they are part of senior management. Not surprisingly, this leads to substantial turnover of direct care staff which, as for clients in the state-operated system, is disruptive. The perspective of the PNPs is that their funding should be increased.

Impacts for the DMHAS-operated and –funded system include increased workload, stress, and difficulty being released for training. Having to "do more with less" is the mantra.

There is a state as well as a nationwide shortage of psychiatrist/prescribers, along with, in some regions, bilingual staff, social workers, and case managers. Training of the existing workforce was also recommended, including educating providers about trauma-informed care, evidence-based practices (EBPs), cultural competence, and safe opioid prescribing practices. <u>*DMHAS Activities on this issue*</u>: *A review of training opportunities for DMHAS staff from the Winter Catalog 2017 and Web-based Trainings: Trauma-informed practice in Behavioral Health Care; Best Practices in Anger Management; Best Practices in the Treatment of Depression and SUD; Addressing behavioral health needs of veterans; Gender-responsive substance abuse treatment for women; Cultural competence primer for behavioral health practitioners and settings; Cultural Elements in treating Hispanic and Latino populations; Understanding Trauma related to Trauma-informed care; and a variety of trainings related to opioids and addiction. Additional training resources are available, but not listed here.*

Issues related to peers also fit in this section. Recovery Coaches serve as mentors/guides for individuals with substance use disorders. The Coach empowers the individual in their personal journey toward recovery by offering hope while providing advocacy, guidance, support and knowledge. Because these positions aren't reimbursable, they're underutilized and not enough positions are available. Use of peers to bridge service gaps is recommended as a cost-effective solution, especially to assist with compliance and follow through for persons being discharged from EDs or otherwise transitioning. Persons experiencing some sort of crisis, including overdose, are at a critical point at which engagement may be most advantageous. The Yale Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence program was put forward as an example of an innovative model to be replicated. Some misunderstandings have developed in terms of the role of the peer, in which some peers conceptualize of themselves as advocates, not actual service providers. There is a waiting list for Recovery University. Creation of more groups with persons in recovery like the Consumer Action Panel in Torrington was suggested. *DMHAS Activities on this issue: DMHAS has an initiative in process to expand the peer workforce into hospital emergency departments*. *Trained recovery coaches will reach out to ED patients and their families to provide assistance when a desire for recovery is indicated. Manchester, Windham, Norwich and New London Hospitals will have Recovery Coaches connect with patients who have overdosed or with alcohol/substance-related ED visits. The goal is for a rapid response by the recovery coaches (≤ 2 hours) to engage the patient and connect them to a provider/recovery supports and with transportation as needed, including resource materials that can be taken with the patient/family at discharge. A second DMHAS initiative is a project covering calendar year 2017 designed to assist agencies with integrating Recovery Support Specialists. This initiative is designed to assist up to ten (10) agencies in supporting and maximizing the contributions peer staff can make to promote the recovery of persons with serious mental illnesses and co-occurring substance use disorders. The training and technical assistance will be provided at no cost to the selected agencies and is funded by DMHAS through the Yale Program for Recovery and Community Health (PRCH) and Advocacy Unlimited.*

#3b-Education/Research/Prevention:

The second priority that was part of the 3-way tie for third most important is Education/Research/Prevention which many expressed were critical across all levels of care. Each element will be addressed separately.

Education of town services staff was suggested along with more required funding and training for Crisis Intervention Training (CIT) for police officers. Additionally, providing accurate information about the negative effects of marijuana was recommended, particularly for young adults. Raising awareness of common mental health conditions and wellness were recommended. *DMHAS Activities on this issue*: *There were 194 MHFA training sessions and 91 YMHFA training sessions in FY 15. For FY 16, there were 152 MHFA training sessions and 74 YMHFA training sessions. As a result of ongoing CIT training sessions, there are now 95 police departments with at least one trained officer and 1754 individual officers trained.*

Research recommendations included collecting data on wait lists, assessing the impact/cost-savings of providing mental health supports, monitoring the impact of budget cuts, and legislative review of standards for merchant education on tobacco, alcohol, medical marijuana and gambling.

Prevention recommendations primarily focused on substance use and suicide with few exceptions. More prevention efforts in K-12 public schools targeting primary substance use prevention and other behavioral health issues was expressed with the concern that social media is playing a role in children trying out substances earlier. Directing prevention efforts toward those at greatest risk of

overdose, making naloxone more accessible to reverse opioid overdoses, and placing medication drop boxes in places where people will be more comfortable using them rather than in police station lobbies were all suggested. Related to suicide prevention, more was recommended, including the Zero Suicide Initiative, along with integrating these efforts to deliver local level support. *DMHAS Activities on this issue: The Governor's Prevention Partnership provided 810 services reaching over 19,000 individuals targeting schools, colleges, workplaces, media and communities. Through the Garrett Lee Smith (GLS) Suicide Prevention Initiative, comprehensive evidence-based suicide prevention/early intervention efforts on college campuses across the state served students with screening and professionals with training. Information on mental health and substance use issues was disseminated through a variety of media outlets to thousands of residents via the Connecticut Center for Prevention, Wellness, and Recovery. The most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.*

There were a few comments related to stigma, including a point of view that the term "behavioral health," which has been adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as many other organizations, is "misleading and increases stigma." Changing society's attitudes is still needed for those with mental health and substance use disorders and their families. *DMHAS Activities on this issue*: *DMHAS has several new public service announcements specific to the opioid epidemic and its consequences on individuals, families, and the community and these have been presented to the Alcohol and Drug Policy Council and are available on the DMHAS website.*

It was suggested that the Strategic Prevention Framework (SPF) which has been in place for years be replaced with a new prevention model and that prevention efforts reach across the life span. Changes were also recommended to the secondary prevention plan to include the programs: SOS, A-SBIRT, QPR and MHFA, some of which are already being offered. Another recommendation was to fund the Connecticut Prevention Network (CPN) to conduct twice annual prevention forums to improve delivery of EBPs.

#3c- Residential/Crisis/Respite:

The third of the 3-way tie for third most important priority is Residential/Crisis/Respite care which covers a wide swath of services. While each element will be addressed separately, some common themes were expressed which applied across the entire range. A lack of capacity across this category was identified and it was pointed out that two transitional residential programs had closed. Stigma was described as a barrier to new housing as everyone is familiar with the NIMBY (Not in My Backyard) phenomenon. A lack of transitional support from 24/7 to step down levels of care was also expressed. Inadequate reimbursement rates for residential treatment and poor pay for residential staff make it difficult to maintain staff and services. For some clients, especially complicated co-occurring clients, the maximum length of stay may still not be enough to result in a successful discharge. Finally, inmates being released from prison with behavioral health needs are challenged to find housing.

Residential services for those with substance use disorders were described as having insufficient capacity to meet the demands. During the waiting period for admission to certain programs, people are expected to call daily to retain their spot on the waiting list, often while they are on the street and at risk of relapse. There are no sobering centers at which to safely wait for residential treatment and no "wet houses" to safely sober up for those not ready for a higher level of care. Some programs won't admit potential clients unless they already have a place to discharge to afterwards which is problematic for clients that are homeless. As mentioned previously, there are also insurance barriers reported such as needing to fail lower levels of care first, needing to be intoxicated at the point of admission, or arbitrary caps on number of episodes of treatment that will be covered. Again, these barriers suggest

incorrect interpretation of the ASAM criteria. It was suggested that more services be directed toward direct client contact early in the recovery process.

Residential housing for those with mental health conditions (group homes or supervised apartments) was described as having insufficient capacity to meet the demands. The Greater Danbury area has no group homes. Residential options for interim and higher levels of care are recommended. Clients become comfortable with their current level of care and stepping them down to a lower level of care becomes a challenge that they resist. They may not have the financial resources to move their belongings. They may have difficulty in relating to others in the household or other issues like hoarding which serve as a barrier to housing options. It was suggested that those persons who hoard should have this condition addressed by both health providers and municipal services. The transition from group home to independence is dramatic and needs an interim level if the person is to succeed. Medicaid Rehab Option (MRO) group homes have requirements including 40 billable hours of services/month which can be a challenge to meet. Also, group homes with more flexibility than the MRO requires were recommended. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations addressing the need for higher intensity mental health residential treatment beds for the more disabled clients challenged by program demands and in need of more extensive assistance than other clients.*

Crisis services are understaffed and lack capacity which translates into reduced hours of service, extensive waits for service, and reliance on a law enforcement response. Strict fidelity/model requirements of mobile crisis limit flexibility and serve as a barrier for some. It was recommended that the evaluation of crisis services be modified to target understanding what the client's experiences were. It was suggested that 23-hour crisis beds be created.

Respite care was described as lacking capacity and as being misused long-term by persons who had no other placement option. Similarly, it was suggested that increasing respite bed capacity might alleviate other capacity issues in the system. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

Other Priorities

Recovery Support Services:

Recovery Support Services did not rank in the top three priorities, but received a number of comments and recommendations. Related to housing, concerns were expressed about trying to access a shelter bed through 211 and CAN, needing a certain income for eligibility for public housing, long waits for Section 8 vouchers and the challenge of housing persons released from prison. Specifically for persons in recovery from substance use disorders, having halfway houses and *supervised* sober houses was emphasized along with a request to maintain people in recovery support services even if noncompliant. Also related to recovery from substance use disorders, it was suggested that alternative to traditional 12-step self-help groups be made available and that services be available 24/7. Concern was expressed over inaccurate online information about mental health services and that clients with such issues weren't always informed about available services, including clubhouses and vocational services.

There were a number of comments and recommendations related to supported employment. Despite efforts to educate clients to the contrary, many still believe that they will lose their benefits if they become employed. Challenges to employment include the overall high unemployment rate, clients with a substance use or criminal justice history, and lack of access to Employment Specialists. Referrals to the Supported Employment program are low, which respondents attributed to Waterbury Hospital not participating in the referral process. This underutilization could be an opportunity for those wishing to participate in supported employment programming. Staff that operate in the Supported Employment

program are challenged by having to develop job opportunities for clients at the same time that they have to support their clients in their recovery process. A suggestion was made to assist clients' efforts at starting their own businesses. The IPS model was described as limiting flexibility and budget cuts to DOC apparently eliminated an option to IPS. *DMHAS Activities on this issue: This concern about lack of flexibility with IPS has been addressed as programs wishing to use an alternate model simply need to put their proposal for an alternate plan in writing for review by the program manager*. *The Supported Employment Grant that DMHAS was awarded is currently working with two priority populations: the Latino population in Hartford and individuals with criminal justice involvement in New Haven.*

Transportation issues were again a significant concern in the priority setting process. Complaints about Logisticare, especially the rudeness and lack of promptness of the drivers, continue and a barrier to being able to lodge complaints against them was described. Recommendations related to transportation included: having mental health and substance use transportation resources shared, enforcing the med cab contract with an emphasis on respectfulness being a must, having the med cab operate in isolated parts of the state, working with towns for use of available town vehicles, replicating the Reliance House model of "punch cards" for rides, supporting a limousine service, funding a mobility coordinating position, and investigating other transportation possibilities. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Special Populations of concern:

As in previous reports, the majority of concerns expressed for special populations were age-related.

Young Adults (YA) – tailoring services for the unique needs of young adults was emphasized. Providing younger adults with services designed for older adults (example provided was traditional AA meetings) is not a good match and fails to engage them. It was recommended that services provided by CCAR be tailored for adolescents.

Special concern was expressed for young adults in college with behavioral health symptoms. Symptoms significant enough to interfere with the student's ability to succeed in this environment are reportedly common, but infrequently reported. College personnel, in turn, are unaware of which students are in trouble and the behavioral health services that are available on campus are often limited. Further complications regard parental notification and consent. For college students with substance use problems, sober campus housing and activities were recommended. This recommendation aligns with suggestions for a Recovery High School for students still in public school who have substance use disorders. Additionally, developing Alternative Peer Groups (APGs) to support young persons in their recovery from substances were recommended. The APG model is a program involving peers to provide positive peer pressure and support.

Persons aging out of DCF appear to have the advantage in accessing young adult services (YAS) which means those without a DCF referral are at a disadvantage. A lack of capacity for YAs at CVH was specified. Not being informed of other available services, including peer supports and treatment outside of DMHAS, was a concern. For those actually receiving services, some reported disrespectful/unhelpful staff, the need for assistance with furthering their education/employment, and clients aging out of YAS without being fully prepared for discharge. *DMHAS Activities on this issue*: *DMHAS YAS program is designed for clients 18 – 25 with a history of DCF involvement and major mental health problems. In SFY 2016, YAS programs served 1,225 clients, an increase of 3.5% over the number served in the previous fiscal year. Almost 50% of clients were able to live independently after discharge from YAS, more than a third had earned a GED/high school diploma, more than a quarter were employed, and over 59% were living stably in the community.*

Older Adults - a service gap identified was older adults with complex medical needs with or without substance use problems who are either house-bound and need services brought in or without residential placement options. In addition, there are older adults with mental health issues who lose family support as they age and are sometimes put in the demanding role of caregivers to other family members. *DMHAS Activities on this issue: The asset mapping project has been completed by the Older Adult Workgroup and subcommittees are actively working on the top priorities which are: 1) Developing and embedding training on older adult mental health issues into other training as part of a professional development effort; 2) identifying existing databases on older adults; 3) creating a process of "no wrong door" for older adults in need of services. Additionally, they are collaborating with DMHAS Workforce Development to create an online training on older adult behavioral health issues for the Learning Management System.*

Co-Occurring Clients –For person struggling with co-occurring conditions, integrated mental health and substance use services should be an expectation, not an exception. It was reported that some mental health services don't want to treat clients on methadone maintenance. *DMHAS Activities on this issue*: *All DMHAS LMHAs are involved in a learning collaborative to offer Buprenorphine as part of MAT. LMHAs have also been participating in naloxone training. Additionally, monitoring conducted by the DMHAS Community Services Division (CSD) of substance use programs examines the extent to which mental health services are provided and at this point, many substance use programs now provide mental health services to the clients they serve.*

Criminal Justice Involved Clients – Many persons who are incarcerated struggle with mental health and/or substance use disorders. Treatment, rather than incarceration, should be indicated. Jail diversion was recommended for expansion along with providing education to judges about the option.

Other populations – Persons in these other special subpopulation groups were only mentioned in terms of needing access to services: hearing impaired persons, hoarders, undocumented persons, persons whose primarily language is other than English, minority LGBTQ youth and young adults, and transgender persons who were described as not supported in the region. *DMHAS Activities on this issue*: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Insurance issues:

Barriers due to insurance practices were illuminated including: spend down requirements, short re-determination periods, Husky C not covering substance use services/residential treatment (a check of this reveals that while Husky C does not cover residential, it does cover inpatient and outpatient services), high co-pays and deductibles, and insurances that aren't accepted by providers (ex. Medicaid).There was a complaint about a young adult being "forced" into Husky insurance even though the person was covered by private insurance.

Integrated/Coordinated/Technology Informed Care:

There was a general call for developing coordination mechanisms to bring providers together on a regular basis to coordinate care for clients that they share. The care provided should be "wraparound" including areas such as housing and medical services.

CCTs and BHH are positive examples of how this can work, but at least for the BHHs, some problems were identified, including that dual eligible clients (Medicare and Medicaid) may not be eligible for BHH, high caseloads, lack of communication across primary and behavioral health providers, "spillover" to CSP or waiting lists, and physicians ignoring medical complaints of mental health clients. A call for integration of medical services at other levels of care outside BHHs was indicated.

Using current technology, including social media to improve centralized registry, help clients find therapists or social/recreational opportunities for clients and those who support them and recommended resources can all be possible with technology.

Emerging Issues

Cuts associated with the budget deficit are foremost on everyone's minds in terms of what the impact will be for services in the state. This concern has overshadowed other issues and was described earlier in this report.

The most frequently identified emerging issue was the Opioid crisis, despite the fact that the epidemic was identified in 2012 and has seen a significant response from the state since that time. The magnitude of the impact of such widespread opioid use, including overdoses, has attracted a lot of attention and consequently this topic was addressed earlier in this report.

Marijuana is an emerging concern as more states around the country are legalizing the drug for medical and recreational use, including neighboring states. Data is just becoming available from states such as Colorado that legalized marijuana a few years ago and can serve to inform Connecticut about likely consequences to be faced. Respondents continue to ask for accurate information on the negative consequences of marijuana use. <u>*DMHAS Activities on this issue*</u>: *A few of the providers in the Connecticut Strategic Prevention Framework Coalitions (CSC) initiative are targeting marijuana in their prevention efforts based on community needs assessments. They include: the Town of Clinton, Rushford (Middletown), Child & Family Agency of Southeastern CT, Inc. (Lyme/Old Lyme), and Ledge Light Health District (Groton). The CT Clearinghouse continues to serve as a resource for education on marijuana and distribution of related materials. Additionally, many prevention evidence-based practices address substances as a whole which may include marijuana.*

Problem gambling was identified as an emerging issue in light of Keno and new casinos being built which will increase accessibility to gambling.

Greater awareness of transgender persons, the stigma they face, and lack of support that appears to be available for them is an issue that has moved to the forefront. <u>*DMHAS Activities on this issue*</u>: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR),*

Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.

Suicide rates have risen and there is concern that at least some of the overdoses reported as accidental-drug-related-deaths might, in fact, be intentional rather than accidental. *DMHAS Activities on this issue*: *DMHAS has been very active and supportive of various suicide prevention programs (e.g., QPR; one word, one voice, one life) which are ongoing across the state. The most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.*

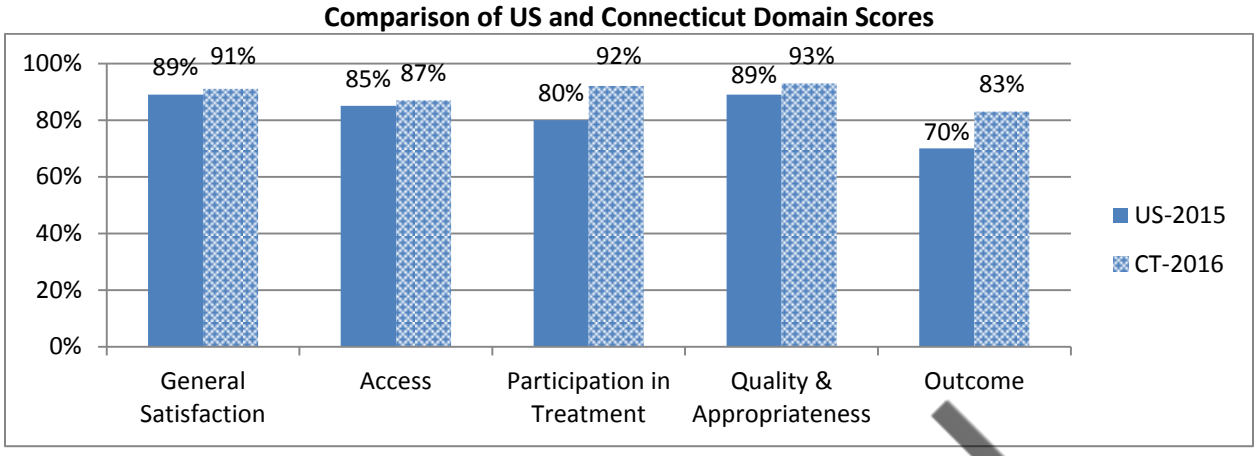
Consumer Satisfaction Survey Measures

DMHAS conducts an annual consumer satisfaction survey in order to better understand consumers' experiences with the public state-operated and community-funded service delivery system, as well as to use these data for quality improvement. The Consumer Survey has been administered annually since 2000 using a version of the Mental Health Statistics Improvement Program's (MHSIP*) Consumer-Oriented Mental Health Report Card.*

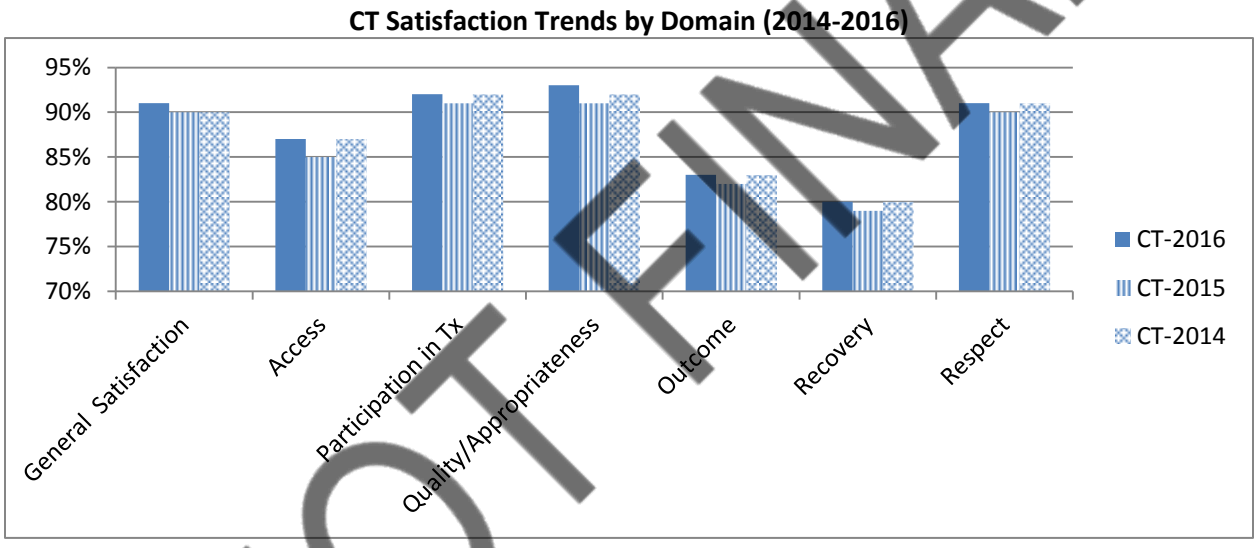
The survey is offered to consumers/individuals in recovery within the context of their treatment for behavioral health issues. Most levels of care are required to participate in the survey. State-operated and private nonprofit providers are required to collect and report results to the Office of the Commissioner, where the data is collated, analyzed and synthesized into an annual report. For FY 2016, over 26,000 surveys from 109 providers within the DMHAS behavioral health system were received. The most recent version of this full report for FY 2016 is available at: http://www.ct.gov/dmhas/lib/dmhas/consumersurvey/CS2016.pdf.

In 2005, DMHAS added the Recovery domain to the MHSIP survey. The Recovery domain is comprised of five questions which assess perception of "recovery oriented services"; these questions were developed in collaboration with the Yale Program for Recovery and Community Health. This addition provides DMHAS with valuable information regarding its success in implementing a recovery-oriented service system. DMHAS also uses an additional Respect domain to collect information about perceived respect towards people in recovery. Two other instruments are included in the survey. The first is the WHPQOL –BREF Quality of Life instrument which is a widely used, standardized quality of life tool developed by the World Health Organization. This 26-item tool measures consumer satisfaction with the quality of the person's life in physical, psychological, social and environmental domains. DMHAS received 1,873 QOL responses. The other tool added is the 8-question Health Outcomes Survey which contains items from the Center for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS). These questions ask about body mass index (BMI), chronic health conditions, overall health from a physical and psychological perspective, and drinking habits. A total of 3,354 surveys were received on these Health Outcome Measures. The national emphasis on the integration of behavioral health and primary health care underscores the importance of these optional tools.

A comparison of consumer survey findings and national results reveal that Connecticut respondents reported higher levels of satisfaction in all consumer satisfaction domains than the national averages, in several cases by a substantial margin.



The following figure shows satisfaction rates over the past three years indicating the stability of the percentages over time.



Group disparities have become a subject of much interest. One of the limitations of the MHSIP is that it was standardized on consumers receiving mental health treatment only, not the broader behavioral health sample which the Connecticut survey includes, specifically, substance use disorder and co-occurring mental health and substance use clients. In examining the group data, the following are highlighted:

- More clients in mental health programs reported satisfaction in the Access, General Satisfaction and Respect domains while more clients in substance use programs reported satisfaction in the Outcome and Recovery domains.
- Across all programs, more women reported satisfaction with services in the Appropriateness, General Satisfaction, Participation in Treatment, and Respect domains while more men reported satisfaction in the Outcome and Recovery domains.
- Across all programs, black clients reported more satisfaction in the Outcome and Recovery domains than white clients.
- Across all programs, Hispanic clients were more satisfied than non-Hispanics in the Access, Appropriateness, Outcome, General Satisfaction and Recovery domains.

- In the General Satisfaction domain, more clients in each older age group were satisfied with services than clients in any younger age categories.

Individual questions on the QOL are scored from 1 to 5 with 1 being the lowest score and 5 being the highest. Domain scores are transformed to a 1 – 100 scale with higher scores indicating more satisfaction with quality of life. Results on the QOL survey found that overall, clients in substance use programs enjoyed better quality of life than clients in mental health programs. This data may be confounded by the fact that more clients in substance use as compared to mental health programs are younger and male.

Quality of Life across Program Type

	Physical Health	Psychological	Social	Environmental	General QOL
All Programs	65.0	65.3	63.2	66.1	68.5
Substance Use	71.9	70.2	68.2	67.5	72.9
Mental Health	62.3	63.3	61.1	65.6	66.6

Additionally, the QOL revealed that:

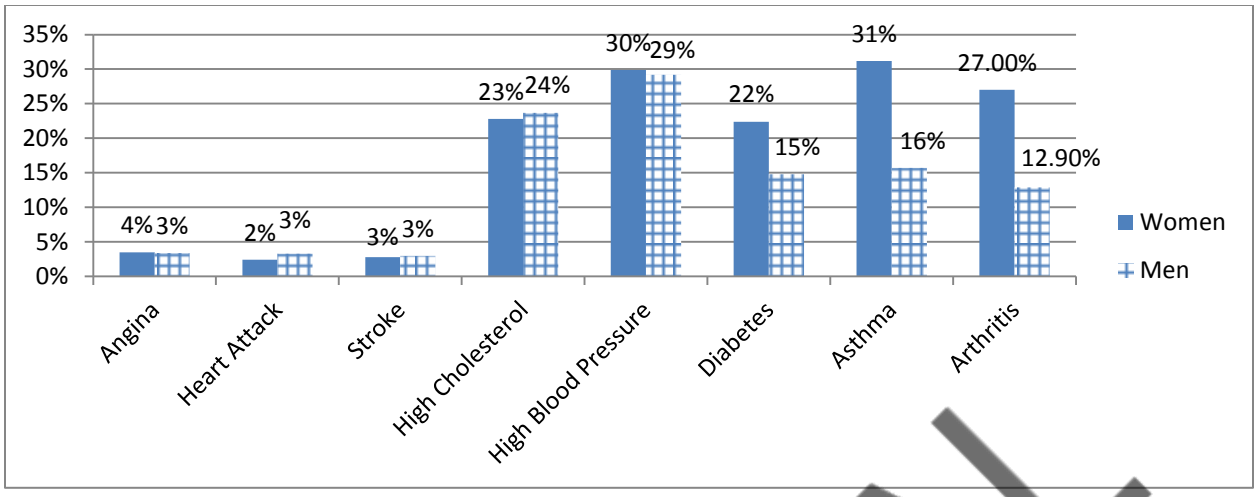
- Across all programs, men reported better QOL than did women for Physical health, Psychological health and General QOL.
- Across all programs, other (non-black and non-white) clients reported better Social QOL than black or white clients.
- There were no differences across programs for Ethnicity.
- Younger clients reported better QOL than older clients across all programs in the Physical Health, Social and General QOL domains.

As part of the SFY2016 Consumer Satisfaction Survey process, DMHAS providers had the option to administer an eight-question Health Outcome Survey. The survey is available in English and Spanish. Body Mass Index (BMI), cardiovascular/respiratory/diabetes disease, overall health from physical and psychological perspectives, and smoking and drinking habits are all items. A total of 3,354 surveys were completed. Sixty-nine percent of the responses came from clients in mental health programs and 30% came from substance use programs.

BMI could be calculated for 76.5% (2,566) of the respondents. The average BMI for clients was calculated as 30.1 ($\pm$8) with the women's average at 31.1 ($\pm$7.2) and the men's average at 29.4 ($\pm$7.2). According to the CDC, BMI categories for adults indicate that:

Underweight or normal BMI	Overweight BMI	Obese BMI
27%	32%	42%

Respondents endorsed the following list of medical conditions:



Despite the medical conditions reported, clients rated themselves with respect to their overall health as follows:

Excellent/Very Good/Good General Health	Fair/Poor General Health
70.1%	29.9%

CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

2016 REPORT ON STATEWIDE PRIORITY SERVICES

January 26, 2017

2016 Statewide Priority Setting Report

Priority Setting Process:

DMHAS' priority setting initiative, designed to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state, began in December 2001. Fundamental to this process are Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) which are statutorily charged to determine local and regional needs and service gaps. Both of these entities, working collaboratively, facilitate a process in each of the five DMHAS regions to assess the priority unmet service and recovery support needs across the mental health and addiction service systems. Since inception in 2006, DMHAS has conducted its priority setting process every other year (in even-numbered years). In the intervening years (odd-numbered years), the RMHBs and RACs provide updates to inform DMHAS of progress made in addressing the identified unmet needs and to alert the department to any emerging issues. As part of this process, RMHBs and RACs use aggregate profile data provided by DMHAS to describe usage of services within their region, provider survey results based on an on-line survey asking for responses about the DMHAS service system, and other sources of information from local needs assessments/surveys and activities. Armed with this information, RMHBs and RACs orchestrate key informant constituency groups (consumers/persons in recovery, family members, providers, referral agencies such as shelters and criminal justice representatives, and local professionals, law enforcement, and town officials) to participate in community conversations, focus groups, and/or structured interview sessions asking about service system barriers, gaps, and concerns. This process results in Regional Priority Reports across the behavioral health continuum. These reports are presented to DMHAS leadership at regional meetings, providing an opportunity for dialogue between the department and regional stakeholders. From the regional reports, a synthesized statewide priority report is created that examines cross regional priorities and solutions. The statewide report is shared and discussed with the Adult State Behavioral Health Planning Council and the Commissioner. DMHAS is indebted to the RMHBs and RACs for their ongoing efforts on behalf of the behavioral health needs of the citizens of Connecticut. Their passion and commitment are evident as they continuously strive to better the lives of persons living with mental health and substance use conditions.

It should be noted that some of the concerns identified in this report exist outside of DMHAS' purview. Matters related to other state agencies or private entities are duly noted, but will not be addressed by DMHAS. Other issues, such as transportation or housing concerns, while beyond DMHAS' ability to manage independently, are topics related to larger behavioral health issues statewide which DMHAS attempts to address jointly in ongoing efforts with other state agencies. Further, there are federal regulations governing the use of block grant funds within which DMHAS must operate. A new feature of this report is the inclusion of DMHAS activities related to identified areas of concern. While there may not be a response for every concern raised, in many instances there are activities ongoing or planned which the reader of the report may have been unaware of.

State Profile of Services:

The number of unduplicated clients served in FY 2016 was 112,864 comprised of 61,341 clients treated in substance use services and 59,225 clients treated in mental health services (including 7,702 clients receiving both). The greatest numbers of clients served came from the most populated regions. There were 107,212 admissions, 60,703 for substance use and 46,509 for mental health. To access the Annual Statistical Report: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2016.pdf.

Demographics of DMHAS clients SFY 2016

	Substance Use	Mental Health	Total
Female	30.4%	51.3%	40.6%
Male	68.6%	48.6%	58.9%
White/Caucasian	65.5%	62.6%	64.0%
Black/African American	13.6%	17.4%	15.7%
Other or missing race	21.0%	20.0%	20.5%
Hispanic/Latino	21.4%	19.5%	20.4%
Non-Hispanic	71.0%	74.5%	72.9%
Unknown ethnicity	7.7%	5.9%	6.7%
18 - 25	17.3%	11.9%	14.4%
26 - 34	29.1%	16.4%	23.0%
35 - 44	20.5%	16.5%	18.8%
45 - 54	18.6%	23.5%	21.4%
55 - 64	10.4%	21.5%	15.7%
65+	2.3%	9.2%	5.4%
Unknown age	1.8%	1.0%	1.3%

While males and females are almost evenly divided in mental health services, in substance use programs, two-thirds of the clients are male. Most clients served in the DMHAS system are white/Caucasian (64%) while the July 1, 2015 census data finds that 81% of Connecticut residents are white/Caucasian. Ostensibly it appears that white/Caucasian clients are underrepresented and black/African American clients are overrepresented in the DMHAS treatment population; however, the category "other or missing race" is sufficiently large to caution against such a conclusion. Similarly, Hispanic/Latino clients comprise 15.4% of Connecticut's population based on census data and are 20.4% of the DMHAS treatment population. Finally, as to age, clients in substance use services tend to be younger than clients receiving mental health services.

For clients receiving mental health services, the primary diagnostic categories are major depression (18.2%), schizophrenic disorder (12.5%), and bipolar disorder (10.4%). When examining primary and non-primary diagnoses, just over half of the clients qualify for an SMI (Serious mental illness) diagnosis, which involves having one or more of the following: schizophrenia (and related disorders), bipolar disorder, and/or major depression. It is interesting to note that two out of three (68%) of all clients (mental health and substance use) have a substance use diagnosis. This is the first year in which heroin has been reported more frequently than alcohol across total new admissions. For clients admitted to substance use services, primary drug use was reported as heroin/other opioids (46.0%) followed by alcohol (33.9%) and marijuana (10.0%).

Most clients in both systems of care participated in outpatient treatment, followed by residential and then inpatient, as can be seen from the table below.

Levels of Care	Substance Use	Mental Health
Outpatient	55,256	58,387
Residential	11,323	2,922
Inpatient	2,717	1,428

With respect to young adults in SFY 2016, DMHAS Young Adult Services (YAS) served 1,225 clients, which represents 7.5% of the total 18 – 25 year old population served by DMHAS (16,235) and reflects a 3.5% increase over the number served in YAS in SFY 2015. YAS serves clients aged 18 – 25 with a history of DCF involvement and major mental health problems.

Structure for Evaluation:

As budgets were tightening, each state agency was required to identify their core functions so a prioritization process with respect to what would be funded could be established. The result of DMHAS' efforts to consolidate its many and varied services into a handful of categories produced the following:

	Inpatient	Outpatient	Residential; Crisis & Respite	Recovery Support Services	Education; Research & Prevention
Mental Health	Psychiatric Forensic Enhanced Security	PHP, IOP, Forensic community, ACT, Case Management, Care Coordination, BHH, Outreach & Engagement, Community Support	Group homes, Transitional, Sub-acute, Mobile Crisis, CIT, Respite, Intensive Residential	Housing/Housing Supports, Supportive Housing, Supervised apartments, Peer Services, Advocacy, Social & Vocational Rehab, Supported Employment & Transportation	Supported Education, Staff Training, Suicide & Violence Prevention
Substance Use	Medically managed & monitored detoxification	IOP, MAT, Ambulatory detoxification, Case Management & Community Support	Intensive, Inter-mediate & Long-term Residential & Halfway Houses	Recovery Houses, Peer Services, Advocacy	Staff Training, Tobacco Retailer Compliance, Violence Prevention , Substance Use Prevention

The biannual priority setting process created a grid to assist in the prioritization process within each region which utilized the 5 core functions identified by DMHAS found in the table above. Based on the various surveys and focus groups held across the state, each region established overarching issues, strengths, top 3 priorities, system gaps/barriers, and emerging issues as well as recommendations. The report which follows covers all these elements, although system gaps/barriers and recommendations are embedded within the topic areas rather than separated out. Again, as noted above, some concerns/recommendations are outside DMHAS' purview/mission or require funds which either may not currently be available or may not be permitted by regulations associated with the federal block grant. DMHAS applauds the efforts of the RMHBs and RACs in their priority setting process, but does not necessarily endorse every finding/recommendation which follows.

Overarching Issues

There was widespread concern about the state's budget and the as yet unknown total impact of cuts of services for persons with behavioral health issues. Even prior to the most recent budget reductions, capacity concerns across levels of care were expressed. Individuals with behavioral health issues sometimes end up in an inappropriate level of care due to a lack of availability at the appropriate level causing a cascade of capacity issues and a system without an adequate flow of clients to meet the demand. Repercussions of current and possibly future additional cuts are expected to make accessing

appropriate care even more challenging; lengthening already long waits, reducing already reduced services, and costing the state more in the long run due to more expensive emergency/crisis situations resulting from lack of timely medication management, psychiatric and substance use assessment, and access to the appropriate level of care when indicated. Access to limited treatments slots is further compounded by perennial basic needs challenges, especially housing and transportation. *DMHAS Activities on this issue: Over the years, during times of budget shortfalls, DMHAS' top priority has always been the maintenance of treatment services. Shortfalls are always applied to non-service related areas first.*

The lack of safe affordable housing contributes to homelessness which results in transient persons not receiving services and being at increased risk for adverse events of all kinds. These individuals are more likely to end up in Emergency Departments (EDs). Despite progress in reducing *chronic* homelessness, those who are more *recently* homeless appear unlikely to get services and providers accuse the Coordinated Access Network (CAN) of being an unfunded mandate that has shifted the homeless from shelters to EDs. Supportive housing can prevent homelessness, promote self-sufficiency, and reduce use of more expensive levels of care. Adequate rental subsidies and support services are needed to provide stability and prevent re-institutionalization. Likewise, sober housing, which can vary dramatically in quality, requires more oversight, licensing, training, and support. "Mixed" housing was viewed as problematic given the different needs of the populations in need, such as older compared to younger adults. *DMHAS Activities on this issue: The 8 CANs in Connecticut are a federal Department of Housing and Urban Development requirement which have resulted in approximately 400 new federal housing subsidies being awarded in 2015 and 2016. Targeting chronic homelessness - the most severe and costly form of homelessness - doesn't end all homelessness as it is a dynamic problem. The Partnership for Strong Communities, through the Reaching Home Campaign, has developed workgroups to address all types of homelessness, including chronic, short-term, Veterans, youth and family. Related to sober housing, Supported Recovery Housing Services (SRHS) are defined as non-clinical, clean, safe, drug and alcohol-free transitional living environment with on-site case management services available. DMHAS's agent, Advanced Behavioral Health, Inc. (ABH) credentials SRHS providers, and contracts with them, to provide housing and case management services to people in recovery. ABH currently contracts with 14 Supported Recovery Housing Service Providers with a total of 48 locations and 208 beds (male/female). Providers may have additional beds not contracted under BHRP, as self-pay beds.*

Lack of transportation is particularly problematic in the more rural areas of the state (Eastern and Northwestern) where there are fewer services to begin with, an argument for greater use of telemedicine or a mobile service that comes to the person. Problems related to Logisticare cite rude drivers and extensive waits which at times result in clients missing/late for appointments and being penalized by the provider. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Across inpatient, hospital and correctional settings there was concern not only that people are discharged prematurely without being sufficiently stabilized, but also that inadequate discharge planning and follow up are contributing to recidivism, re-institutionalization, and even suicide shortly after release. While medications may be managed while the person is in the inpatient setting, longer-term wraparound supports are needed for the client and their family to increase the odds of a sustained recovery. Family members of a person with behavioral health issues need support and assistance with keeping their family intact. More follow up is needed to make sure that persons discharged get connected to the next level of care. *DMHAS Activities on this issue*: *There are emerging initiatives between Department of Correction (DOC) and DMHAS outpatient substance abuse services to ensure*

better connections to care for persons pre-release from DOC. These efforts are an extension of such programs operating in Bridgeport and New Haven that will now be expanded to Hartford.

Opioid Epidemic

The structure of the priority setting process in 2016 was based on large service categories and did not lend itself to organizing around topics like the opioid epidemic; however, given the scale of the problem it is being separately addressed. Admissions rates for persons with a primary diagnosis of heroin continue to climb, as, unfortunately, do the number of opioid-involved overdoses across the state. Often the overdoses occur within a few weeks of release from hospitals, prisons, and other institutions due to a decrease in tolerance to the substance caused by a break in use. Some concern was expressed about an apparent emphasis on methadone in response to the opioid epidemic. Other treatment options are, of course, available at DMHAS programs, but medication assisted treatment (MAT) is an evidence-based practice proven to decrease illicit drug use, criminal activity, and infections. The suggestion to allow Advanced Practice Registered Nurses to be able to prescribe Suboxone and thereby further expand access to this medication has been accomplished by federal law via the Comprehensive Addiction Recovery Act (CARA 2016). Safe disposal of unused and expired medications has received much attention as about 75 police station lobbies across the state now have medication drop boxes, however, it's been suggested that more convenient drop box locations are needed outside of police stations for those who are uncomfortable with this location or have difficulty accessing it due to age or disability. The new DMHAS call line meant to assist those with opioid use disorders to access services was commented on during the priority setting process with the feedback that some callers had been told the number was only for persons using certain substances, not all substances, and only for those in need of detoxification. Those needing other services were advised to call 211. The 211 call number has also received comment, including that most people lack awareness of this service and that the 211 system needs more staffing and more training, including in customer service skills. *DMHAS Activities on this issue: This topic has resulted in positive cross agency and community stakeholder collaborations. Significant resources have been dedicated to raising awareness and educating the public via community forums and public service announcements. Expansion of (MAT) through methadone clinics and suboxone prescribing are underway and more is expected as DMHAS received a SAMHSA grant for this purpose. Training on Naloxone for opioid overdose reversals is ongoing with clinicians, administrators, police officers, school personnel, and other organizations and community members.*

Strengths

Responding to Current Conditions:

Much positive legislative activity has occurred related to current crises situations. Related to the opioid epidemic, reestablishing the Alcohol and Drug Policy Council (ADPC), establishing a 7-day limit on prescribing of opioids, raising the capacity for physicians with the DATA waiver to prescribe buprenorphine, medication drop boxes for safe disposing of prescription medications, more first responders armed with naloxone, RAC funding, and pending agreements to place recovery coaches/crisis workers in EDs are all underway.

Mental health clients in crisis have the benefit of staff expertise and services that continue to become more integrated. Local Mental Health Authorities (LMHAs), working with law enforcement, other emergency responders, and town personnel continue to coordinate to serve those in need. Both Crisis Intervention Training (CIT) for police and Mental Health First Aid (MHFA) training for community members continue to be offered and seem to be making a difference in terms of greater understanding and recognition of common behavioral health crises. In response to barriers in accessing timely mental health services, some programs now offer same day or next day access.

Integration Efforts:

Community Care Teams (CCTs) have been developed in many locales and are targeting frequent ED users/Inpatient admissions and assisting those clients with wraparound services which address the wellness of the whole person. It was suggested that the cost savings realized from the activities of the CCT should be sufficient to fund a navigator for each CCT. It was recommended that there be coordination amongst the existing CCTs to ensure consistency of services provided.

Behavioral Health Homes (BHHs) are serving those with complex medical needs by either establishing medical clinics onsite or establishing a close working relationship with a nearby hospital for medical services. Some providers have become certified Federally Qualified Health Centers (FQHCs).

Greater awareness and collaboration between behavioral health and law enforcement providers is benefitting both systems and has resulted in more training and greater familiarity of mental health and substance use initiatives.

Homelessness:

Coordinated Access Network (CAN) has made progress toward ending chronic homelessness and there are two supportive housing options in Manchester described as "stellar".

Wellness:

The concept of treating the whole person known as "wellness" continues to gain momentum. To a certain extent, dissatisfaction with the existing system (including instances of doctors not listening to clients or minimizing their medical issues or focusing only on medication) has been the impetus to the rise of the wellness phenomenon in which clients are empowered and the focus is on meeting their own needs. This is consistent with recommendations to teach clients self-awareness and self-care and having them develop skills rather than having providers do it for them. The need for less focus on diagnosis and more on providing alternatives and actual help, as was noted from the respondents, captures this. Involving more people in the wellness movement as a prevention effort was recommended because of its increased client participation and cost-effectiveness. This would include mindfulness, art and self-expression activities. Others propose having actual tutoring in math and writing skills. The TOIVO program offers education, support groups and alternative approaches to healing and wellness. The In Shape program, which focuses on exercise and nutrition, uses positive reinforcement with participants and is successfully reducing stress and anxiety. Some clubhouses are offering activities and groups that people want to participate in, like smoking cessation, yoga, healthy eating, and spirituality, and in an environment where those participating also develop friendships. Another provider has incorporated skill building, wellness groups and activities that are also drawing people in that might not otherwise be interested.

Recovery Supports:

Connecticut has invested in training certified Recovery Support Specialists through Advocacy Unlimited (AU) and Recovery Coaches through Connecticut Community for Addiction Recovery (CCAR). Many are working in the system, providing support for socializing, recreation, self-advocacy, employment, and community living skills.

DMHAS and its providers are committed to recovery support services, including services provided by CCAR (Recovery Coaching training, telephone support, and volunteer opportunities). Clubhouses and social programs are helping people develop relationships and success in the community by assisting them with education and training, support, activities, and stress reduction.

Top 3 Priorities

#1- Outpatient Services:

Outpatient services were of greatest concern statewide due primarily to limited access/capacity. Some programs have closed due to budget reductions or financial losses associated with insufficient Medicaid reimbursement amounts. The other barriers identified were a shortage of psychiatrists/prescribers and, of those practicing, many not accepting public insurance, including Medicaid. This situation is characterized by extended waits for outpatient appointments and larger caseloads for outpatient personnel. In response to the situation, some outpatient providers, rather than close, have cut back on services and hours, including replacing individual with group sessions, focusing on medication management rather than client skill development, and eliminating the possibilities of any extended service hours or bilingual staff. On the other hand, some providers have opted to attempt a same day access model, which was applauded by respondents and considered worth attaching incentives to.

More provision of services by case managers, CSP and ACT providers and other support services were recommended not just to assist targeted clients in maintaining treatment gains, but to make available to the overall population. Likewise, Outreach & Engagement, which is also part of the "Outpatient" category, were recommended for those in transition between different levels of care (including release from prison to community), persons who drop out of treatment, those in crisis, persons without transportation, persons with substance use disorders, seniors with behavioral health issues, and homeless persons. A number of participants felt they weren't adequately informed of all the outpatient services that were available to them, including peer supports. There was also the mention of having navigators available to assist clients with identifying and accessing resources. *DMHAS Activities on this issue*: *DMHAS just completed a redesign of residential support services and converted many programs to Community Support Programs (CSPs) to provide better standardization of services. There are now 28 agencies and 39 distinct CSP programs available.*

For persons with substance use disorders, accessing suboxone providers for opioid replacement therapy (ORT) has been a challenge given federal limits on the number of persons a prescriber can have on their caseload. The Department of Health and Human Services (DHHS) has recently expanded this capacity which should make this care more accessible. It was also reported that Ambulatory Detox is an underutilized level of care that more people could access. *DMHAS Activities on this issue*: *DMHAS was awarded a grant for high risk communities to expand access to Buprenorphine. The communities of Torrington, Bristol/New Britain, and Willimantic/Windham will not only receive funds to support expansion of Buprenorphine treatment but will also be able to hire a recovery coach at each site to assist in the process.*

The nationwide shortage of psychiatrists will not be resolved quickly given they are an aging profession with many working only part time.

#2-Inpatient Services:

Extended waits to access inpatient beds were reported with many persons occupying general hospital beds/"boarding" in EDs for the interim. The hospitals believe they are seeing more clients coming to them with behavioral health concerns. It was reported that it is particularly challenging to access inpatient beds for clients with co-occurring conditions and that community inpatient programs are reluctant to accept these more complicated co-occurring clients, preferring to leave such clients to state-operated programs like Connecticut Valley Hospital (CVH). One recommendation in this regard is to shift designation of some inpatient beds to be strictly for co-occurring clients.

For clients with substance use disorders, it's reported that accessing an inpatient bed is difficult unless the person is referred through the court/criminal justice system. Complaints about persons needing to be "high" at the time of admission screening or that they need to "fail" at a lower level of

care to be admitted suggest that improper use of the American Society of Addiction Medicine (ASAM) admission criteria is occurring. Other unnecessary barriers include programs refusing persons prescribed psychotropics or certain arbitrary dosages of methadone. Complaints about insurance company barriers included dictating treatment options and caps on number of treatment episodes.

Mental health clients at CVH were reported to not be receiving sufficient therapeutic groups, adequate visitation opportunities or sufficient coordination with lower levels of care (LOCs) and housing options.

Across all inpatient settings there was concern that people are discharged prematurely – staying only long enough to have their medications managed, but not long enough to be stabilized and to acquire the skills needed to be successful at discharge. Better discharge planning/aftercare arrangements are needed including longer-term transitional wraparound supports for the whole family, in order to increase the chances for a sustained recovery. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

#3a- Workforce:

The first priority that was part of a 3-way tie for third most important is workforce. The state-operated system has been affected by layoffs which result in "bumping" per union contract. Impacts of this "bumping" include disruption for services and clients, including potential loss of a particular expertise/specialty.

At the private non-profits (PNPs), those providing direct services to clients are described as the "working poor", unless they are part of senior management. Not surprisingly, this leads to substantial turnover of direct care staff which, as for clients in the state-operated system, is disruptive. The perspective of the PNPs is that their funding should be increased.

Impacts for the DMHAS-operated and –funded system include increased workload, stress, and difficulty being released for training. Having to "do more with less" is the mantra.

There is a state as well as a nationwide shortage of psychiatrist/prescribers, along with, in some regions, bilingual staff, social workers, and case managers. Training of the existing workforce was also recommended, including educating providers about trauma-informed care, evidence-based practices (EBPs), cultural competence, and safe opioid prescribing practices. *DMHAS Activities on this issue*: *A review of training opportunities for DMHAS staff from the Winter Catalog 2017 and Web-based Trainings: Trauma-informed practice in Behavioral Health Care; Best Practices in Anger Management; Best Practices in the Treatment of Depression and SUD; Addressing behavioral health needs of veterans; Gender-responsive substance abuse treatment for women; Cultural competence primer for behavioral health practitioners and settings; Cultural Elements in treating Hispanic and Latino populations; Understanding Trauma related to Trauma-informed care; and a variety of trainings related to opioids and addiction. Additional training resources are available, but not listed here.*

Issues related to peers also fit in this section. Recovery Coaches serve as mentors/guides for individuals with substance use disorders. The Coach empowers the individual in their personal journey toward recovery by offering hope while providing advocacy, guidance, support and knowledge. Because these positions aren't reimbursable, they're underutilized and not enough positions are available. Use of peers to bridge service gaps is recommended as a cost-effective solution, especially to assist with compliance and follow through for persons being discharged from EDs or otherwise transitioning. Persons experiencing some sort of crisis, including overdose, are at a critical point at which engagement may be most advantageous. The Yale Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence program was put forward as an example of an innovative model to be replicated. Some misunderstandings have developed in terms of the role of the peer, in which some

peers conceptualize of themselves as advocates, not actual service providers. There is a waiting list for Recovery University. Creation of more groups with persons in recovery like the Consumer Action Panel in Torrington was suggested. *DMHAS Activities on this issue: DMHAS has an initiative in process to expand the peer workforce into hospital emergency departments*. *Trained recovery coaches will reach out to ED patients and their families to provide assistance when a desire for recovery is indicated. Manchester, Windham, Norwich and New London Hospitals will have Recovery Coaches connect with patients who have overdosed or with alcohol/substance-related ED visits. The goal is for a rapid response by the recovery coaches (≤ 2 hours) to engage the patient and connect them to a provider/recovery supports and with transportation as needed, including resource materials that can be taken with the patient/family at discharge. A second DMHAS initiative is a project covering calendar year 2017 designed to assist agencies with integrating Recovery Support Specialists. This initiative is designed to assist up to ten (10) agencies in supporting and maximizing the contributions peer staff can make to promote the recovery of persons with serious mental illnesses and co-occurring substance use disorders. The training and technical assistance will be provided at no cost to the selected agencies and is funded by DMHAS through the Yale Program for Recovery and Community Health (PRCH) and Advocacy Unlimited.*

#3b-Education/Research/Prevention:

The second priority that was part of the 3-way tie for third most important is Education/Research/Prevention which many expressed were critical across all levels of care. Each element will be addressed separately.

Education of town services staff was suggested along with more required funding and training for Crisis Intervention Training (CIT) for police officers. Additionally, providing accurate information about the negative effects of marijuana was recommended, particularly for young adults. Raising awareness of common mental health conditions and wellness were recommended. *DMHAS Activities on this issue*: *There were 194 MHFA training sessions and 91 YMHFA training sessions in FY 15. For FY 16, there were 152 MHFA training sessions and 74 YMHFA training sessions. As a result of ongoing CIT training sessions, there are now 95 police departments with at least one trained officer and 1754 individual officers trained.*

Research recommendations included collecting data on wait lists, assessing the impact/cost-savings of providing mental health supports, monitoring the impact of budget cuts, and legislative review of standards for merchant education on tobacco, alcohol, medical marijuana and gambling.

Prevention recommendations primarily focused on substance use and suicide with few exceptions. More prevention efforts in K-12 public schools targeting primary substance use prevention and other behavioral health issues was expressed with the concern that social media is playing a role in children trying out substances earlier. Directing prevention efforts toward those at greatest risk of overdose, making naloxone more accessible to reverse opioid overdoses, and placing medication drop boxes in places where people will be more comfortable using them rather than in police station lobbies were all suggested. Related to suicide prevention, more was recommended, including the Zero Suicide Initiative, along with integrating these efforts to deliver local level support. *DMHAS Activities on this issue: The Governor's Prevention Partnership provided 810 services reaching over 19,000 individuals targeting schools, colleges, workplaces, media and communities. Through the Garrett Lee Smith (GLS) Suicide Prevention Initiative, comprehensive evidence-based suicide prevention/early intervention efforts on college campuses across the state served students with screening and professionals with training. Information on mental health and substance use issues was disseminated through a variety of media outlets to thousands of residents via the Connecticut Center for Prevention, Wellness, and Recovery. The*

most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.

There were a few comments related to stigma, including a point of view that the term "behavioral health," which has been adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as many other organizations, is "misleading and increases stigma." Changing society's attitudes is still needed for those with mental health and substance use disorders and their families. *DMHAS Activities on this issue*: *DMHAS has several new public service announcements specific to the opioid epidemic and its consequences on individuals, families, and the community and these have been presented to the Alcohol and Drug Policy Council and are available on the DMHAS website.*

It was suggested that the Strategic Prevention Framework (SPF) which has been in place for years be replaced with a new prevention model and that prevention efforts reach across the life span. Changes were also recommended to the secondary prevention plan to include the programs: SOS, A-SBIRT, QPR and MHFA, some of which are already being offered. Another recommendation was to fund the Connecticut Prevention Network (CPN) to conduct twice annual prevention forums to improve delivery of EBPs.

#3c- Residential/Crisis/Respite:

The third of the 3-way tie for third most important priority is Residential/Crisis/Respite care which covers a wide swath of services. While each element will be addressed separately, some common themes were expressed which applied across the entire range. A lack of capacity across this category was identified and it was pointed out that two transitional residential programs had closed. Stigma was described as a barrier to new housing as everyone is familiar with the NIMBY (Not in My Backyard) phenomenon. A lack of transitional support from 24/7 to step down levels of care was also expressed. Inadequate reimbursement rates for residential treatment and poor pay for residential staff make it difficult to maintain staff and services. For some clients, especially complicated co-occurring clients, the maximum length of stay may still not be enough to result in a successful discharge. Finally, inmates being released from prison with behavioral health needs are challenged to find housing.

Residential services for those with substance use disorders were described as having insufficient capacity to meet the demands. During the waiting period for admission to certain programs, people are expected to call daily to retain their spot on the waiting list, often while they are on the street and at risk of relapse. There are no sobering centers at which to safely wait for residential treatment and no "wet houses" to safely sober up for those not ready for a higher level of care. Some programs won't admit potential clients unless they already have a place to discharge to afterwards which is problematic for clients that are homeless. As mentioned previously, there are also insurance barriers reported such as needing to fail lower levels of care first, needing to be intoxicated at the point of admission, or arbitrary caps on number of episodes of treatment that will be covered. Again, these barriers suggest incorrect interpretation of the ASAM criteria. It was suggested that more services be directed toward direct client contact early in the recovery process.

Residential housing for those with mental health conditions (group homes or supervised apartments) was described as having insufficient capacity to meet the demands. The Greater Danbury area has no group homes. Residential options for interim and higher levels of care are recommended. Clients become comfortable with their current level of care and stepping them down to a lower level of care becomes a challenge that they resist. They may not have the financial resources to move their belongings. They may have difficulty in relating to others in the household or other issues like hoarding which serve as a barrier to housing options. It was suggested that those persons who hoard should have this condition addressed by both health providers and municipal services. The transition from group home to independence is dramatic and needs an interim level if the person is to succeed. Medicaid

Rehab Option (MRO) group homes have requirements including 40 billable hours of services/month which can be a challenge to meet. Also, group homes with more flexibility than the MRO requires were recommended. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations addressing the need for higher intensity mental health residential treatment beds for the more disabled clients challenged by program demands and in need of more extensive assistance than other clients.*

Crisis services are understaffed and lack capacity which translates into reduced hours of service, extensive waits for service, and reliance on a law enforcement response. Strict fidelity/model requirements of mobile crisis limit flexibility and serve as a barrier for some. It was recommended that the evaluation of crisis services be modified to target understanding what the client's experiences were. It was suggested that 23-hour crisis beds be created.

Respite care was described as lacking capacity and as being misused long-term by persons who had no other placement option. Similarly, it was suggested that increasing respite bed capacity might alleviate other capacity issues in the system. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

Other Priorities

Recovery Support Services:

Recovery Support Services did not rank in the top three priorities, but received a number of comments and recommendations. Related to housing, concerns were expressed about trying to access a shelter bed through 211 and CAN, needing a certain income for eligibility for public housing, long waits for Section 8 vouchers and the challenge of housing persons released from prison. Specifically for persons in recovery from substance use disorders, having halfway houses and *supervised* sober houses was emphasized along with a request to maintain people in recovery support services even if noncompliant. Also related to recovery from substance use disorders, it was suggested that alternative to traditional 12-step self-help groups be made available and that services be available 24/7. Concern was expressed over inaccurate online information about mental health services and that clients with such issues weren't always informed about available services, including clubhouses and vocational services.

There were a number of comments and recommendations related to supported employment. Despite efforts to educate clients to the contrary, many still believe that they will lose their benefits if they become employed. Challenges to employment include the overall high unemployment rate, clients with a substance use or criminal justice history, and lack of access to Employment Specialists. Referrals to the Supported Employment program are low, which respondents attributed to Waterbury Hospital not participating in the referral process. This underutilization could be an opportunity for those wishing to participate in supported employment programming. Staff that operate in the Supported Employment program are challenged by having to develop job opportunities for clients at the same time that they have to support their clients in their recovery process. A suggestion was made to assist clients' efforts at starting their own businesses. The IPS model was described as limiting flexibility and budget cuts to DOC apparently eliminated an option to IPS. *DMHAS Activities on this issue: This concern about lack of flexibility with IPS has been addressed as programs wishing to use an alternate model simply need to put their proposal for an alternate plan in writing for review by the program manager*. *The Supported Employment Grant that DMHAS was awarded is currently working with two priority populations: the Latino population in Hartford and individuals with criminal justice involvement in New Haven.*

Transportation issues were again a significant concern in the priority setting process. Complaints about Logisticare, especially the rudeness and lack of promptness of the drivers, continue and a barrier to being able to lodge complaints against them was described. Recommendations related to

transportation included: having mental health and substance use transportation resources shared, enforcing the med cab contract with an emphasis on respectfulness being a must, having the med cab operate in isolated parts of the state, working with towns for use of available town vehicles, replicating the Reliance House model of "punch cards" for rides, supporting a limousine service, funding a mobility coordinating position, and investigating other transportation possibilities. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Special Populations of concern:

As in previous reports, the majority of concerns expressed for special populations were age-related.

Young Adults (YA) – tailoring services for the unique needs of young adults was emphasized. Providing younger adults with services designed for older adults (example provided was traditional AA meetings) is not a good match and fails to engage them. It was recommended that services provided by CCAR be tailored for adolescents.

Special concern was expressed for young adults in college with behavioral health symptoms. Symptoms significant enough to interfere with the student's ability to succeed in this environment are reportedly common, but infrequently reported. College personnel, in turn, are unaware of which students are in trouble and the behavioral health services that are available on campus are often limited. Further complications regard parental notification and consent. For college students with substance use problems, sober campus housing and activities were recommended. This recommendation aligns with suggestions for a Recovery High School for students still in public school who have substance use disorders. Additionally, developing Alternative Peer Groups (APGs) to support young persons in their recovery from substances were recommended. The APG model is a program involving peers to provide positive peer pressure and support.

Persons aging out of DCF appear to have the advantage in accessing young adult services (YAS) which means those without a DCF referral are at a disadvantage. A lack of capacity for YAs at CVH was specified. Not being informed of other available services, including peer supports and treatment outside of DMHAS, was a concern. For those actually receiving services, some reported disrespectful/unhelpful staff, the need for assistance with furthering their education/employment, and clients aging out of YAS without being fully prepared for discharge. *DMHAS Activities on this issue*: *DMHAS YAS program is designed for clients 18 – 25 with a history of DCF involvement and major mental health problems. In SFY 2016, YAS programs served 1,225 clients, an increase of 3.5% over the number served in the previous fiscal year. Almost 50% of clients were able to live independently after discharge from YAS, more than a third had earned a GED/high school diploma, more than a quarter were employed, and over 59% were living stably in the community.*

Older Adults - a service gap identified was older adults with complex medical needs with or without substance use problems who are either house-bound and need services brought in or without residential placement options. In addition, there are older adults with mental health issues who lose family support as they age and are sometimes put in the demanding role of caregivers to other family members. *DMHAS Activities on this issue: The asset mapping project has been completed by the Older Adult Workgroup and subcommittees are actively working on the top priorities which are: 1) Developing and embedding training on older adult mental health issues into other training as part of a professional development effort; 2) identifying existing databases on older adults; 3) creating a process of "no wrong door" for older adults in need of services. Additionally, they are collaborating with DMHAS Workforce Development to create an online training on older adult behavioral health issues for the Learning Management System.*

Co-Occurring Clients –For person struggling with co-occurring conditions, integrated mental health and substance use services should be an expectation, not an exception. It was reported that some mental health services don't want to treat clients on methadone maintenance. *DMHAS Activities on this issue*: *All DMHAS LMHAs are involved in a learning collaborative to offer Buprenorphine as part of MAT. LMHAs have also been participating in naloxone training. Additionally, monitoring conducted by the DMHAS Community Services Division (CSD) of substance use programs examines the extent to which mental health services are provided and at this point, many substance use programs now provide mental health services to the clients they serve.*

Criminal Justice Involved Clients – Many persons who are incarcerated struggle with mental health and/or substance use disorders. Treatment, rather than incarceration, should be indicated. Jail diversion was recommended for expansion along with providing education to judges about the option.

Other populations – Persons in these other special subpopulation groups were only mentioned in terms of needing access to services: hearing impaired persons, hoarders, undocumented persons, persons whose primarily language is other than English, minority LGBTQ youth and young adults, and transgender persons who were described as not supported in the region. *DMHAS Activities on this issue*: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Insurance issues:

Barriers due to insurance practices were illuminated including: spend down requirements, short re-determination periods, Husky C not covering substance use services/residential treatment (a check of this reveals that while Husky C does not cover residential, it does cover inpatient and outpatient services), high co-pays and deductibles, and insurances that aren't accepted by providers (ex. Medicaid).There was a complaint about a young adult being "forced" into Husky insurance even though the person was covered by private insurance.

Integrated/Coordinated/Technology Informed Care:

There was a general call for developing coordination mechanisms to bring providers together on a regular basis to coordinate care for clients that they share. The care provided should be "wraparound" including areas such as housing and medical services.

CCTs and BHH are positive examples of how this can work, but at least for the BHHs, some problems were identified, including that dual eligible clients (Medicare and Medicaid) may not be eligible for BHH, high caseloads, lack of communication across primary and behavioral health providers, "spillover" to CSP or waiting lists, and physicians ignoring medical complaints of mental health clients. A call for integration of medical services at other levels of care outside BHHs was indicated.

Using current technology, including social media to improve centralized registry, help clients find therapists or social/recreational opportunities for clients and those who support them and recommended resources can all be possible with technology.

Emerging Issues

Cuts associated with the budget deficit are foremost on everyone's minds in terms of what the impact will be for services in the state. This concern has overshadowed other issues and was described earlier in this report.

The most frequently identified emerging issue was the Opioid crisis, despite the fact that the epidemic was identified in 2012 and has seen a significant response from the state since that time. The magnitude of the impact of such widespread opioid use, including overdoses, has attracted a lot of attention and consequently this topic was addressed earlier in this report.

Marijuana is an emerging concern as more states around the country are legalizing the drug for medical and recreational use, including neighboring states. Data is just becoming available from states such as Colorado that legalized marijuana a few years ago and can serve to inform Connecticut about likely consequences to be faced. Respondents continue to ask for accurate information on the negative consequences of marijuana use. <u>*DMHAS Activities on this issue*</u>: *A few of the providers in the Connecticut Strategic Prevention Framework Coalitions (CSC) initiative are targeting marijuana in their prevention efforts based on community needs assessments. They include: the Town of Clinton, Rushford (Middletown), Child & Family Agency of Southeastern CT, Inc. (Lyme/Old Lyme), and Ledge Light Health District (Groton). The CT Clearinghouse continues to serve as a resource for education on marijuana and distribution of related materials. Additionally, many prevention evidence-based practices address substances as a whole which may include marijuana.*

Problem gambling was identified as an emerging issue in light of Keno and new casinos being built which will increase accessibility to gambling.

Greater awareness of transgender persons, the stigma they face, and lack of support that appears to be available for them is an issue that has moved to the forefront. <u>*DMHAS Activities on this issue*</u>: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Suicide rates have risen and there is concern that at least some of the overdoses reported as accidental-drug-related-deaths might, in fact, be intentional rather than accidental. <u>*DMHAS Activities on this issue*</u>: *DMHAS has been very active and supportive of various suicide prevention programs (e.g., QPR; one word, one voice, one life) which are ongoing across the state. The most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.*

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03/30/16

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03/30/16

State Epidemiological Outcomes Workgroup (SEOW)

Kick-off Meeting
March 30, 2016

DMHAS Center for Prevention Evaluation and Statistics
(CPES)

University of Connecticut Health Center

SEOW Agencies/Organizations

- AIDS Connecticut
- Center for Public Health and Health Policy
- Child Health and Development Institute of Connecticut (CHDI)
- Connecticut Data Collaborative
- CT Hospital Association
- Connecticut Youth Services Association
- Department of Children and Families
- Department of Consumer Protection
- Department of Corrections
- Department of Emergency Services and Public Protection
- Department of Mental Health and Addiction Services
- Department of Public Health
- Department of Social Services
- Department of Transportation
- Judicial Branch, Court Support Services Division
- Multicultural Leadership Institute
- Office of Early Childhood
- Office of the Child Advocate
- Office of Policy Management
- Regional Action Councils
- State Department of Education
- UConn Health Center

Overall SEOW Goals

- Increase access to data that may inform inter-agency planning and collaboration
- Increase cross-agency understanding of the strengths and limitations of available datasets
- Share state agency areas of expertise and knowledge to access, interpret and use data
- Maximize the use of data
- Promote data-driven decision-making to improve planning, evaluation and more effective and efficient targeting of prevention resources
- Explore and expand opportunities for collaboration around issues of common concern
- Contribute to development of an interactive data repository

Specific Tasks of the SEOW

- Identify, collect and analyze data related to behavioral health problems
- Assess data quality and utility
- Support a statewide needs assessment that measures the prevalence and distribution of substance use and mental health-related problems
- Identify indicators of risk and protective factors for substance use and related problems
- Identify populations experiencing health disparities
- Disseminate data to increase access to a greater number of stakeholders

SEOW History and Accomplishments

- Convened in 2005 to support implementation of the Strategic Prevention Framework – State Incentive Grant (SPF-SIG)
- Continued through the first Partnership for Success (PFS) grant (2009-2015)
- Accomplishments:
  - Comprehensive set of substance use-related indicators
  - Assessment of data quality and usability
  - Epidemiological profiles of key substance problems
  - Prioritized substances based on magnitude, impact and changeability of identified substance problems
  - Provided a mechanism to share data and increase understanding of data applications
  - Initial exploration of a behavioral health indicators portal
  - Increased community-level access to data related to substance use

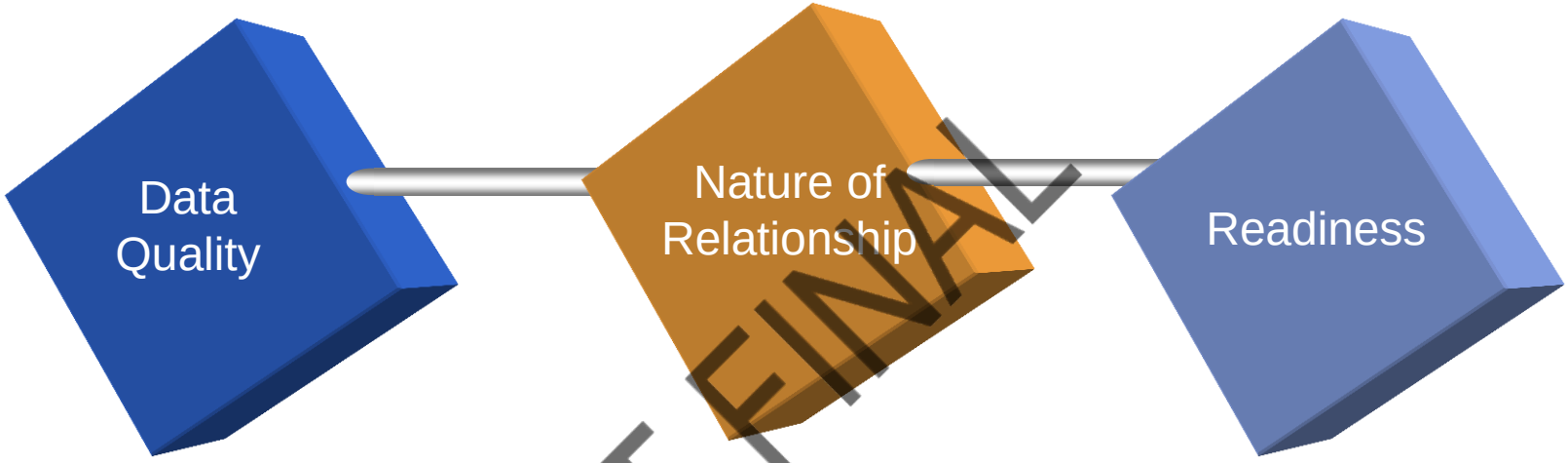
SPF-SIG Substance Use Data

- Population Data
  - Census Data
  - School Enrollment
- Consumption Data
  - National Survey on Drug Use and Health (NSDUH) Youth Risk Behavior Surveillance Survey (YRBSS)
  - Core Survey of College Students
  - Behavioral Risk Factor Surveillance Survey (BRFSS)
  - State Surveys
  - Sales Receipts for Tobacco and Alcohol

SPF-SIG Substance Use Data

- Consequences Data
  - Morbidity Data (DPH)
  - Mortality Data
  - CT Poison Control Center
  - Substance Abuse Treatment Utilization Data (DMHAS)
  - Hospital Utilization Data (CHIME/DPH)
  - Motor Vehicle Crashes (FARS, NHTSA)
  - Crime Data (UCR, DPS/FBI)
  - Drug Enforcement (DEA Reports)
  - School Expulsions/Suspensions and Drop-out Rates (SDE)
  - Child Abuse/Neglect Cases (DCF)

Criteria for Selecting Indicators



1. Ability to analyze data at community level
2. Availability over time
3. Accessibility
4. Capacity for sub-group analysis
5. Data completeness

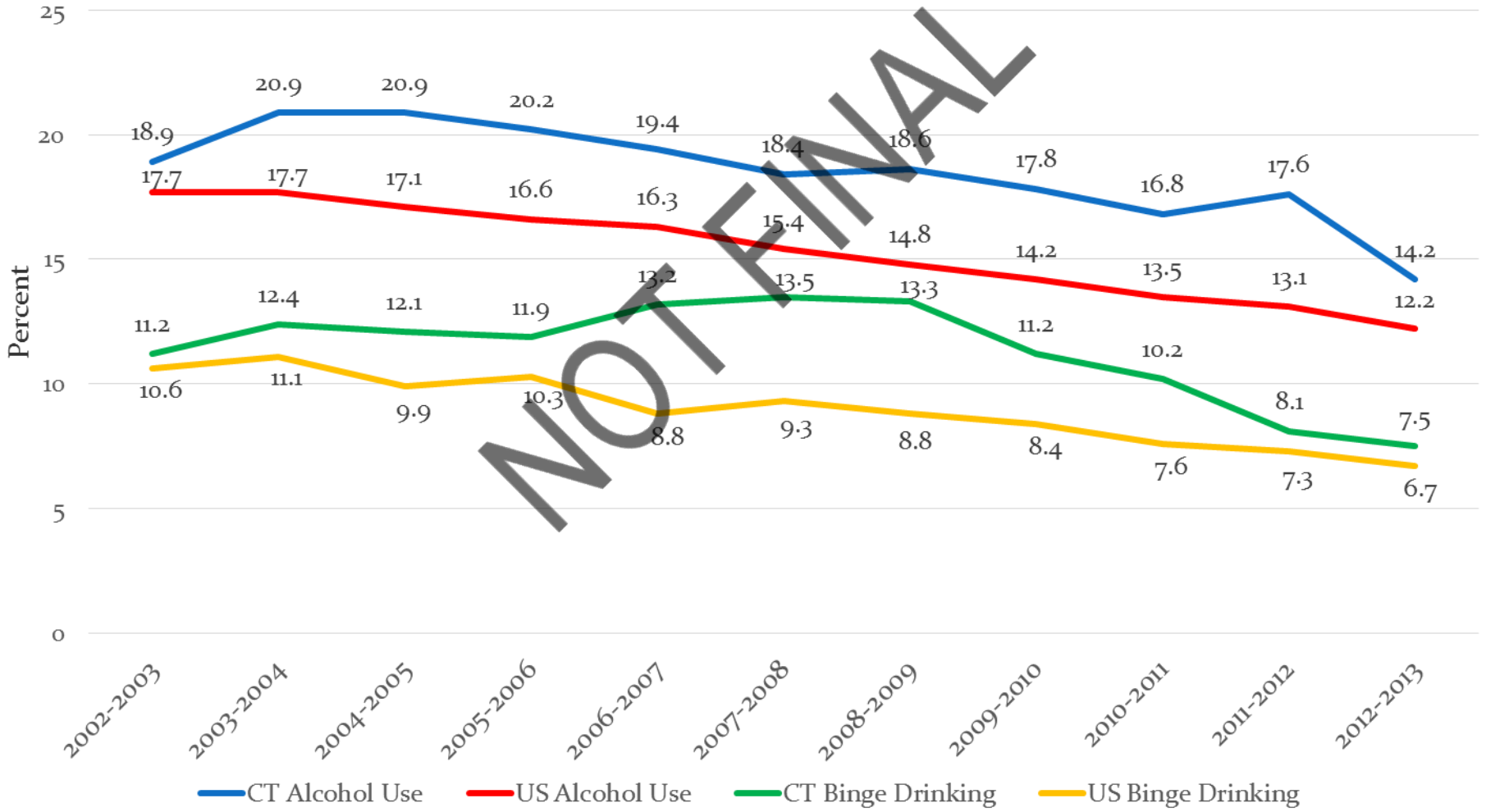
6. Clarity of relationship with substance use
7. Sensitivity to change in consumption
8. Magnitude
9. Impact
10. Changeability

11. Consensus that the issue is important
12. Resources available to implement identified strategies
13. Identified strategies are acceptable
14. Benefit-cost is reasonable

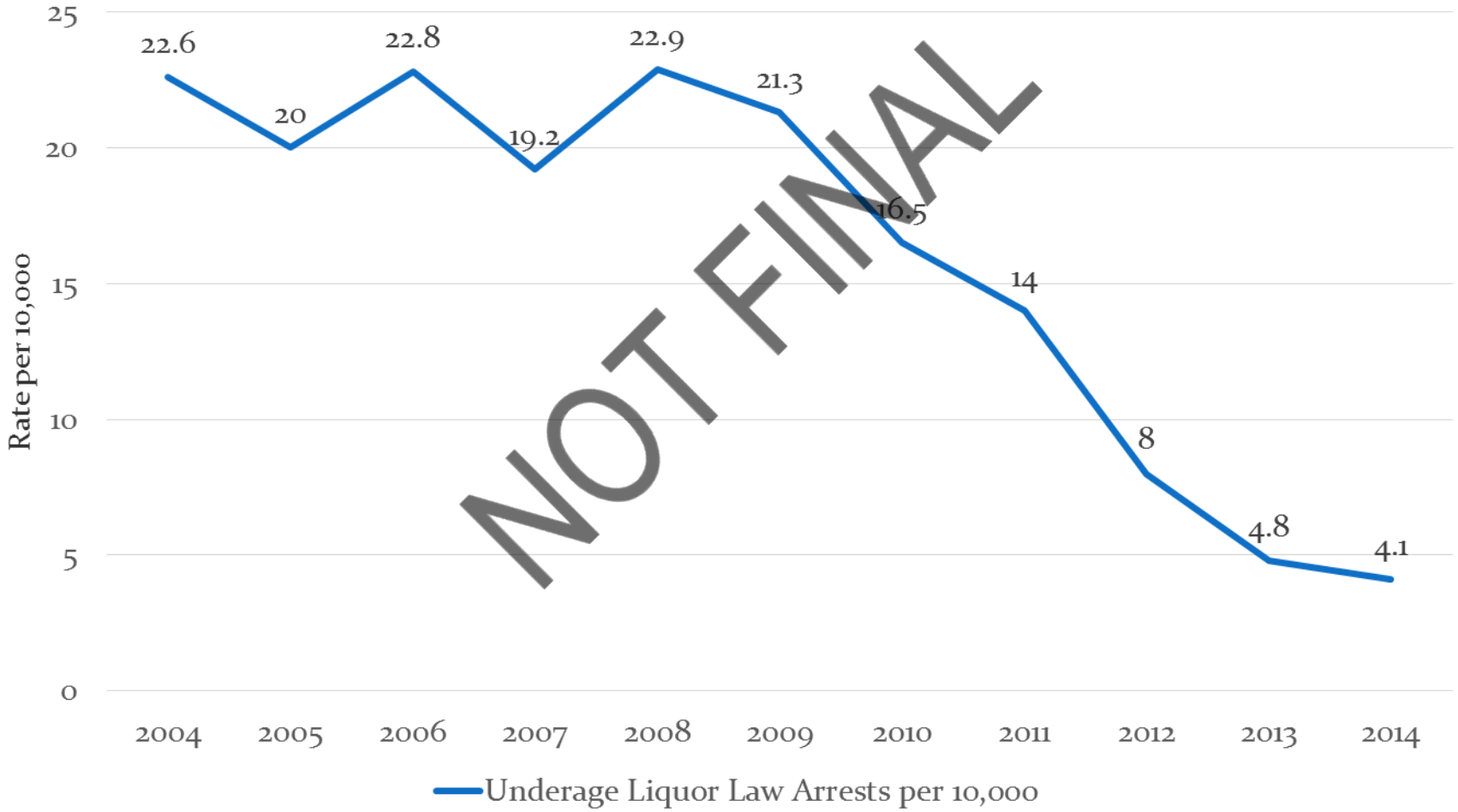
SEOW-Identified Priority Substances for Connecticut, 2005

1. Alcohol*
2. Tobacco
3. Marijuana
4. Heroin
5. Cocaine
6. Prescription Drug Misuse

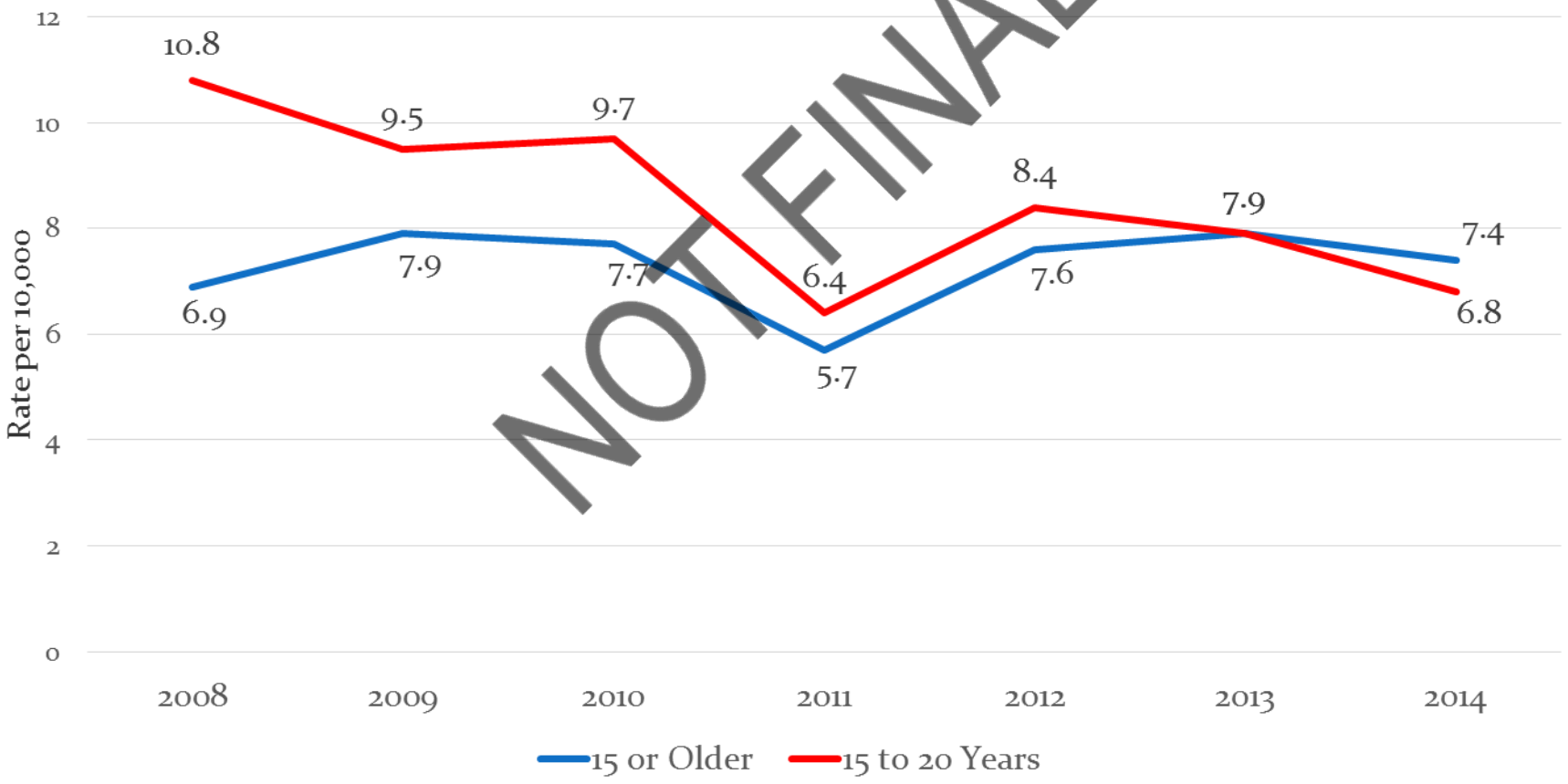
Past Month Alcohol Use and Binge Drinking among Youth 12 to 17: CT vs. US, National Survey of Drug Use and Health, 2002-2003 to 2012-2013



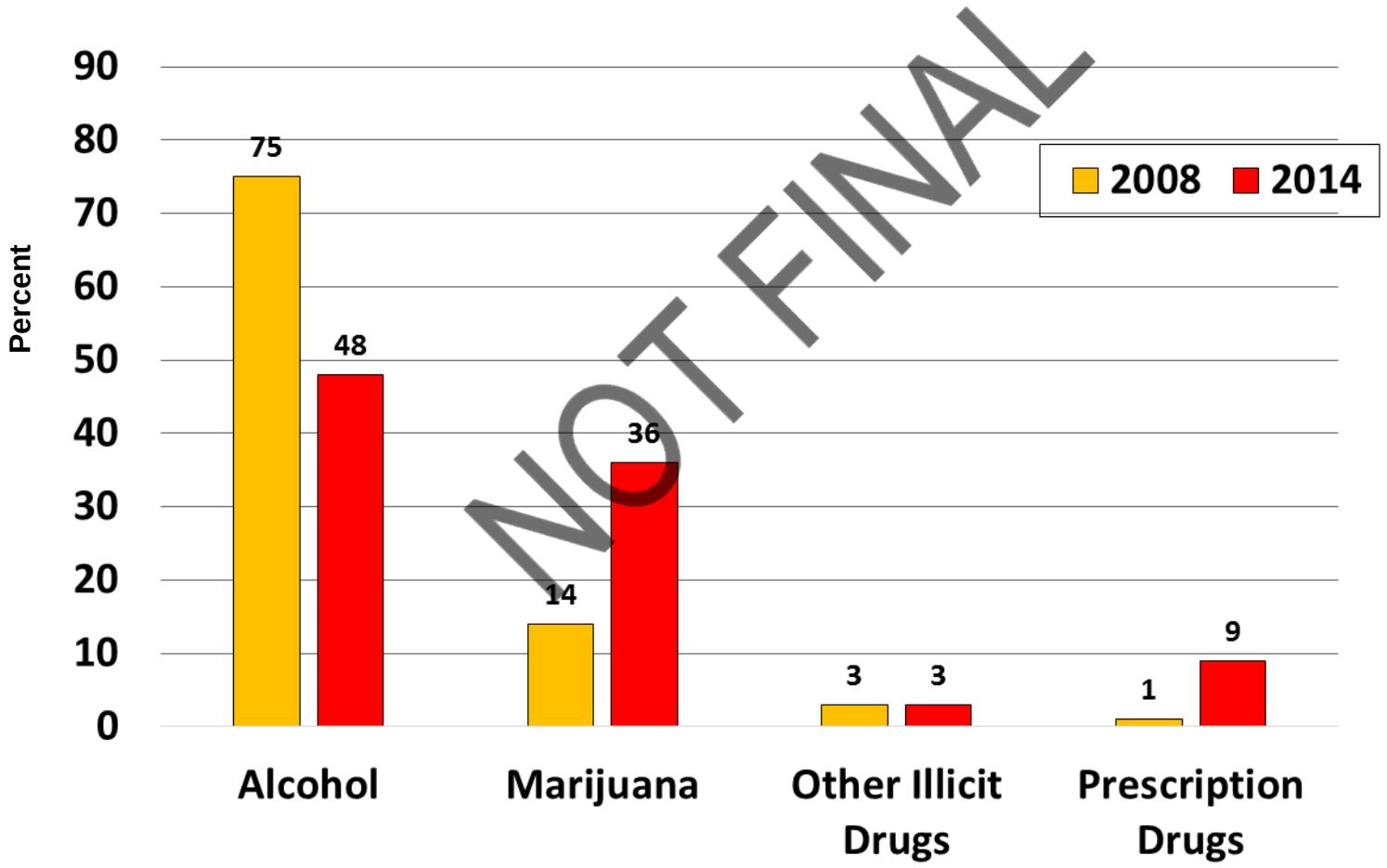
Trend in the Rate of Underage Liquor Law Arrests per 10,000 Population Age 10 to 20: Connecticut, 2004 - 2014



Alcohol-Related Motor Vehicle Accidents per 10,000 Population Aged 15 to 20 Years Old vs. Population Aged 15 or Older: Connecticut, 2008 - 2014



Substance Problem of Greatest Concern in Youth Ages 12-17 According to Key Informants: Connecticut, Community Readiness Survey, 2008 vs. 2014



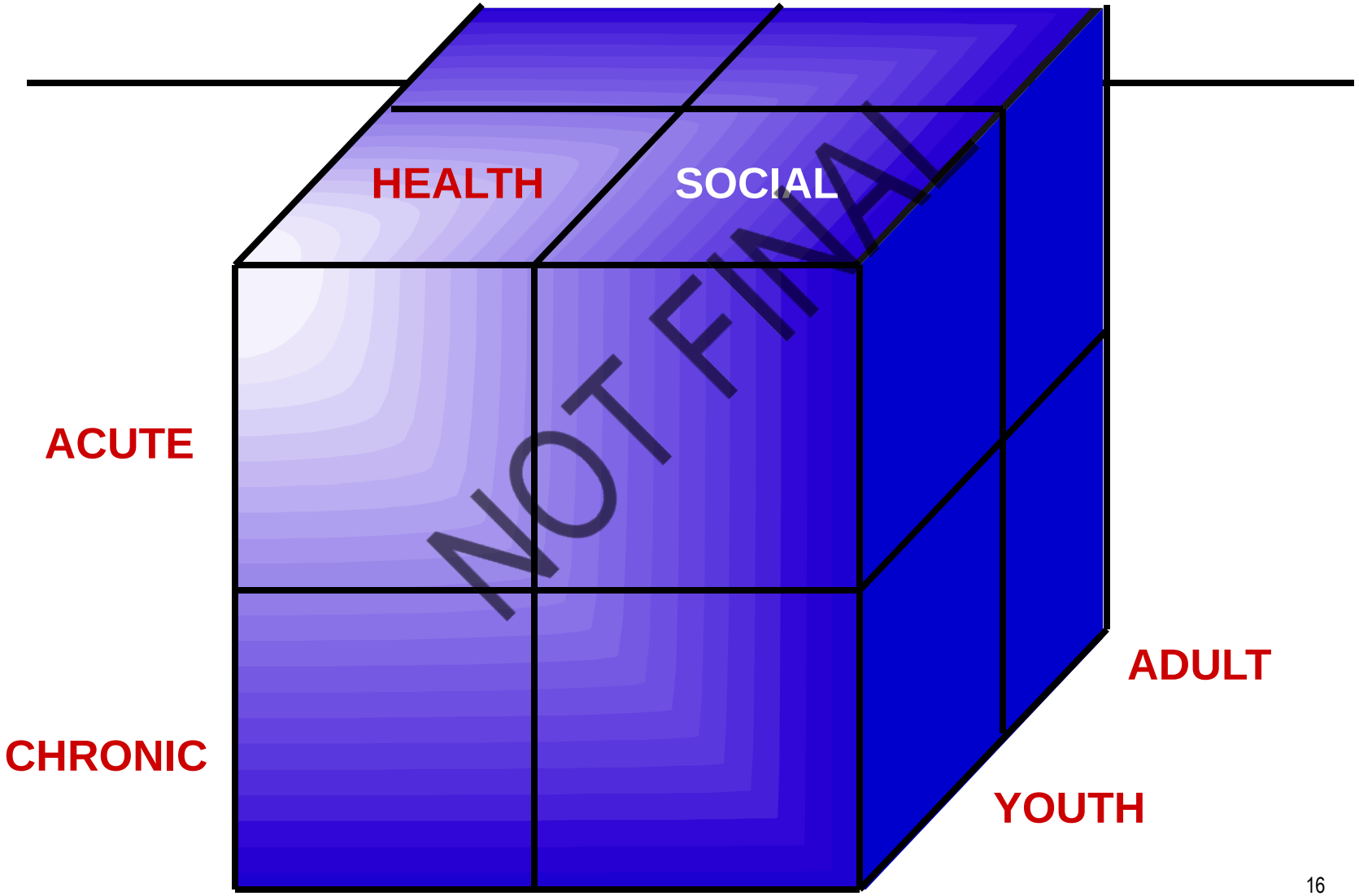
Assess Substance Use Related Problems

- **Identify and obtain consumption and consequence data**
- **Assess the quality (availability, reliability, etc.) of the data**
- **Analyze data according to impact on society/individuals including severity, economic costs, trends, and health disparities.**

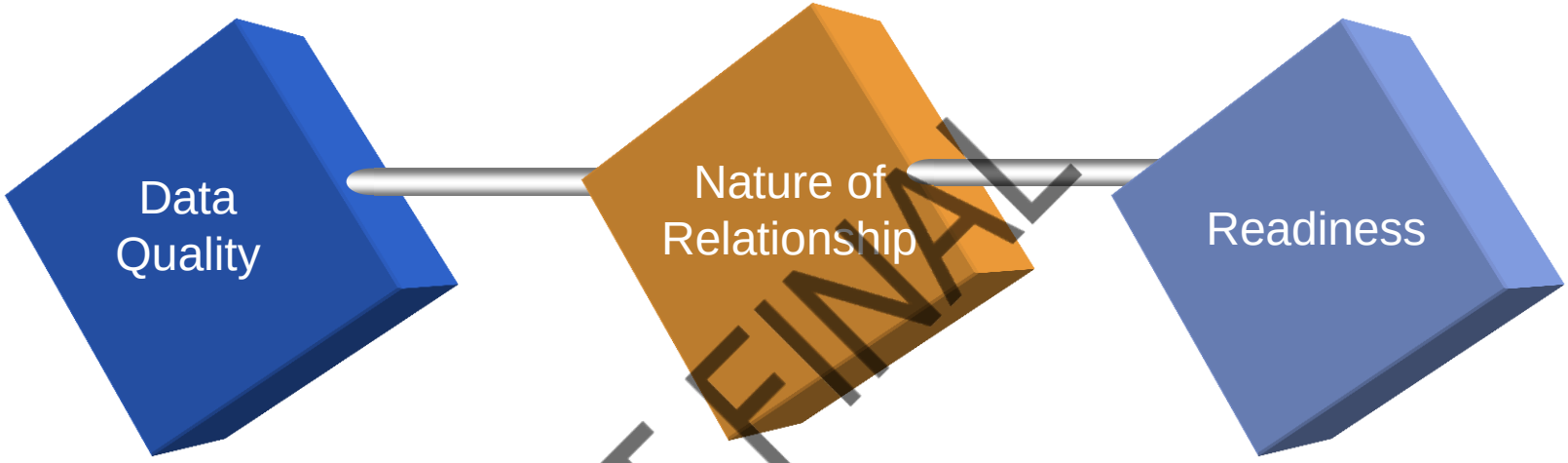
Assess the Burden of the Problem

- **What is the size of the problem?**
- **How serious is the problem?**
- **Who is affected the most?**
- **What are the trends over time?**

SUBSTANCE PROBLEM MATRIX



Criteria for Selecting Indicators



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The SEOW Going Forward

- Expand Data/Indicators
  - Prescription drugs and opioids (risk factors and consequences)
  - Emerging substance issues
  - Mental health
  - Physical and social determinants of health
  - Subpopulations at greater risk for health disparities
  - Other data of interest/use
- Prioritize indicators and assess data quality and usability
- Inform the development of an interactive data portal to support substance abuse prevention and mental health promotion initiatives in CT

The SEOW Going Forward

- Promote collaboration
  - Among agencies and organizations
  - Among parallel data initiatives

    (CT Data Collaborative, CT Open Data Initiative, Data Integration Workgroup, others?)
  - Between State and community stakeholders
- Increase data sharing and accessibility
- Support and inform the work of the ADPC
- Build a SEOW that is responsive to the evolving data climate in the State

Children's Plan Step II

Identify the unmet service needs and critical gaps within the current system

Connecticut is the 29th most populated state with a total population of about 3,576,500, and about 761,795 or 21.3% are children and youth under the age of eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, approximately 10% of Connecticut children are in need of mental health services in Connecticut. (20% may have behavioral health symptoms). Despite the strengths of the Connecticut system mentioned above, a number of families with children with SED, struggle to find support and treatment.

Families experience a number of barriers to treatment including a highly fragmented system in which access varies according to such factors as insurance status, involvement in child welfare or juvenile justice, race and ethnicity, language, and geographic location. In addition, the array of services lacks sufficient inclusion of supports for all children and families that promote nurturing relationships and environments that foster social, emotional, and behavioral wellness.

As the result of the tragedy in Newtown in December of 2012, Connecticut developed a comprehensive plan to guide the efforts of multiple stake holders in developing a children's behavioral health system that builds on existing strengths and addresses the challenges that exist.

The Connecticut legislation addressing the children's behavioral health system called for the development of a ***"comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children."***

The Plan provided Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy development for all children. It is the findings and recommendations from this plan that identified the unmet service needs and critical gaps within the current system.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a

coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

Four core values drive the development of a children's behavioral health system:

- Family-driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- Culturally and linguistically appropriate, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care;
- Trauma informed, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and mechanisms for care coordination, with families, children and youth as full participants in the governance of that system.

A Steering Team and a 36-member Advisory Committee oversaw the planning process and development of the plan. The core elements of the input-gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth;
- Open forums held in six locations and attended by 232 individuals;
- Facilitated discussions on 12 specific topic areas, attended by 220 individuals;
- Website input forms submitted by over 175 individuals and groups;
- A review of background documents and data pertaining to the children's behavioral health system in Connecticut.

The process yielded the identification of the following seven thematic areas and specific goals that Connecticut will use to make significant improvements to the children's behavioral health service system:

1. System Organization, Financing and Accountability
Implementing an enhanced children's behavioral health system of care will require a significant re- structuring with respect to public financing, organizational structure, integration of commercial payers, and data reporting infrastructure.

Goal 1.-A. Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

A core finding from a number of sources is that the children's behavioral health services are, at times, fragmented, inefficient and difficult to access for children and families. Those issues would be substantially improved by integration of public funding that brings together multiple payers and streamlines eligibility, enrollment, service arrays, documentation, and reimbursement mechanisms. Strategies in this area include the following:

i. Identify existing spending on children's behavioral health services and supports across all state agencies.
ii. Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.
iii. Explore mechanisms for pooling funding across all state agencies.
iv. Identify a full array of services and supports that will constitute the children's behavioral health system of care
v. Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.
vi. Identify and address workforce development needs in the children's behavioral health system of care.

Goal 1.-B. Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" can improve outcomes for children and lower costs of behavioral health services. A Care Management Entity has the potential, as a model, to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies and accountability, and reduce costs by disseminating information on behavioral health services, connecting families to services, and providing ongoing care coordination. This will help improve the family's experience of a culturally and linguistically appropriate system with a single point of access that helps families access information and navigate care. Strategies in this area include the following:

i. Design and implement a Care Management Entity to create an effective care coordination system based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.

ii. Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.

Goal 1.-C. Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

Given that insurance companies and self-insured employers currently cover approximately 56% of children and youth in Connecticut, their participation in the children's behavioral health system of care is critical. Concerns about behavioral health services for children and families with commercial insurance arose in the majority of meetings held to gather input into Plan development. Those concerns can be categorized in the following five areas: Coverage for selected services; adequacy of coverage/services for selected conditions; medical necessity criteria and utilization management and review procedures; adequacy of provider networks; and perceived cost shifting to individuals and the State.

Based on the redesign of the publicly financed system, the incorporation of a Care Management Entity, and the demonstration of outcomes and cost savings, the commercial insurance sector will be incentivized to participate in the children's behavioral health system of care. Strategies include the following:

i. Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions.

ii. Apply findings from the process described above to self-funded/employee-sponsored plans.

Goal 1.-D. Develop an agency- and program-wide integrated behavioral health data collection, management, analysis, and reporting infrastructure across an integrated public behavioral health system of care.

A core element of the plan is an emphasis on data and incorporation of results-based accountability. Implementation of the behavioral health system of care requires full attention to the development of data infrastructure for the purposes of monitoring and improving access to services, service quality, outcomes and costs. At the practice level, the collection, analysis, and reporting of data is already an element of evidence-based treatments; yet many other behavioral health services do not currently benefit from systematic data collection, analysis, reporting, standardized training and practice

development and quality improvement activities. Specific strategies to be implemented in this area include the following:

i. Convene a statewide Data-Driven Accountability (DDA) committee to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.
ii. Utilize reliable standards to guide the new data collection, management, and reporting system.
iii. Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.
iv. Increase State capacity to analyze data and report the results.

2. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan. The plan includes strategies that employ prevention-focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services.

Goal 2.A. Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders for children and youth of all ages. Connecticut has a wealth of expertise and programmatic efforts to train early care, education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. However, they reach different audiences and have not been taken to scale to reach children of all ages. (See also Strategy 3.-C. regarding professional development for school personnel in behavioral health).

The key strategy in this area is:

i. Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the statewide need.

Goal 2.-B. All children will receive age appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Screening and early identification are important steps toward avoiding more severe behavioral health challenges over time and deeper involvement in the behavioral health system, this is true for young children and adolescents alike. In addition to the children's behavioral health system; parents and other child-serving systems play a critical role in this effort. Key strategies in this area include the following:

i. Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life allowing for improved coordination of care.
ii. Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

Goal 2.-C. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.
Providers who work with children and youth need to have specific and developmentally appropriate competencies to assist in behavioral health promotion and prevention, and to recognize and respond to early warning signs or concerns. As those who work with young children need very specific training and have the opportunity to make the biggest difference in setting children on the right developmental trajectory, the Plan suggests beginning with this group of providers. Training for providers working with older children is covered as part of the implementation of specific interventions and through training of school personnel (Goal 3.-C). The following strategy is recommended:

i. Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

Goal 2.-D. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Focus on promotion and universal prevention strategies including continued support for statewide suicide prevention activities, to reduce risk factors and promote protective factors.

3. Access to a Comprehensive Array of Services and Supports

Goal 3.-A. Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.

The current array of services is insufficient for meeting child and family behavioral health needs, as manifested in lack of knowledge about the service array, long waitlists for some services and high emergency department utilization. In addition, the proposed expansion of screening to identify behavioral health needs will likely increase the number of youth in need of care, and must be accompanied by an expansion of services to meet those needs. There are currently wide variations in access to and utilization of the array of services among families as the result of such factors as: Past and current child welfare and juvenile justice system involvement; insurance coverage; race, ethnicity and language; and geographic location. De-linking those factors from a family's ability to access a full array of services and supports will go a long way towards meeting the behavioral health needs of all children and families. The use of evidence-based, evidence-informed practices together with innovative and customized services, is highly recommended.

Service expansion in the following areas:

- Early childhood interventions with emphasis on an array of evidence-based interventions from low to high intensity, delivered in a variety of settings;
- Non-traditional/non-clinical services that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, mental health symptoms;
- Care coordination utilizing high-fidelity Wraparound and child and family teaming approaches;
- Behavioral health treatment options including: outpatient care; intensive treatment models; child and adolescent psychiatry; substance use services; and services and supports for children with autism;
- Crisis response services and school-based behavioral health services are also recommended for expansion, which are described in more detail below.

Specific strategies in this area include the following:

i. Establish an ongoing needs assessment protocol, across local, regional, and statewide levels.

ii. Finance the expansion of the services and supports within the array that have demonstrated gaps.

Goal 3.-B. Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

High utilization of EDs can be addressed through expansion of crisis-oriented services, as well as other elements of the service array. Emergency Mobile Psychiatric Services (EMPS) Mobile Crisis is a proven service that helps divert youth from entering the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission, and providing linkages for families to community-based care. Connections between EMPS and a statewide network of crisis stabilization beds will also help address the current crisis in ED settings. Strategies in this area include:

i. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services including the expected MOA's between EMPS and local school districts.

ii. Enhance partnerships between EMPS clinicians and EDs to facilitate effective diversions and linkages from EDs to community-based services.

iii. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

Goal 3.-C. Strengthen the role of schools in addressing the behavioral needs of students.

School-based behavioral health is a key area for expansion of the behavioral health service array that can positively impact all children and should result in substantial overall cost savings through early identification and early intervention. Stakeholders across the state consistently identified schools as playing a critical role in identifying and delivering behavioral health services and supports. The input- gathering process made it clear that the primary mission of schools is to educate students; however, it was widely recognized that students are best prepared to learn when they are healthy and equipped with social, emotional, and behavioral regulation skills and competencies. The state should provide support to schools to address students' behavioral health needs.

Efforts to expand school-based behavioral health services should include co-location of community- based clinicians in schools, additional school-employed behavioral health staff with adequate numbers of behavioral health clinicians, and expansion of School Based Health Centers. All efforts to expand school-based behavioral health care must be coordinated with community-based agencies so that children and families who are identified and/or treated in schools have access to the full array of services offered at community-based clinics, and are assured continuity of care during the summer months. Schools must also closely collaborate with EMPS and with police. School-based behavioral health efforts should pay particular attention to ensuring that youth with behavioral health needs are not disproportionately excluded from the learning

environment due to behaviors that may lead to arrest, expulsion, and out-of-school suspension.

Strategies in this area include the following:

i. Develop and implement a plan to expand school-based behavioral health services.
ii. Create a blended funding strategy to support expansion of school-based behavioral health services.
iii. Develop and implement a behavioral health professional development curriculum for school personnel.
iv. Require formal collaborations between schools and the community.

Goal 3.-D. Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Improve coordination and access to a full service array of suicide prevention activities to support families with children and youth in an acute crisis.

4. Pediatric Primary Care and Behavioral Health Care Integration
Goal 4.-A. Strengthen connections between pediatric primary care and behavioral health services.

Pediatric primary care provides a unique opportunity to screen for and address children's behavioral health needs from a family-based perspective. Child health providers, through the medical home model of care, are an important community-based resource for delivery of health and behavioral health services, as many youth and families access a range of services through their pediatrician. Connections among pediatricians, schools, community-based behavioral health agencies, and other settings, however, need to be strengthened. Connecticut has several initiatives and models in place for improving these connections including the State Innovation Model (See below), Access Mental Health, and Enhanced Care Clinics (See above). These models can be considered when determining how best to address this goal. Strategies in this area include the following:

i. Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.
ii. Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices.

iii. Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.
iv. Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health, or staff from sites working on behalf of medical homes.
v. Reform state confidentiality laws to allow for sharing of behavioral health information between health and behavioral health providers.

5. Disparities in Access to Culturally Appropriate Care

Goal 5.-A. Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Families and other stakeholders in the children's behavioral health system identified a number of concerns regarding disparities in access to culturally and linguistically appropriate services. At the broadest level, families expressed a lack of awareness of and access to culturally and linguistically competent services and supports in the existing behavioral health care system. Families requested an expansion of the workforce and the service array to include staff that are from the same community and speak the same language as the families they serve, gender-specific interventions, and enhanced access for families in the most rural areas of the state. Culturally specific marketing, stigma/discrimination reduction, and related materials are needed, along with training provided to all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs) of each family, in accordance with Culturally and Linguistically Appropriate Services (CLAS) standards. Although specific strategies are offered in this section, additional attention to disparities and cultural and linguistic competence are addressed in other sections of the report. Specific strategies in this area include the following:

i. Conduct an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.
ii. Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.
iii. Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

Goal 5.-B. Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

Specific strategies in this area include the following:

i. Enhance training and supervision in cultural competency.

ii. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.
iii. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

6. Family and Youth Engagement

Goal 6.-A. Include family members of children and youth with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

Multiple stakeholders, including families, confirmed that a critical element in the development and implementation of a children's system of behavioral health care is the ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services. At the systems-level, numerous stakeholders, including families, strongly urged that youth, family members, and family/youth advocates have "a seat at the table" in the governance and oversight of the service delivery system and that these roles be paid positions. At the service delivery level, family-advocacy as well as parent and peer support groups were highlighted as important elements of the workforce and the service array. Stakeholders highlighted the importance of opportunities for regular family and youth input and feedback into service delivery at the local and regional level. Strategies in this area include the following:

i. Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.
ii. Expand the capacity of organizations providing family advocacy services at the systems and practice levels.
iii. Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.
iv. Provide funding to support at least annual offerings of the Community Conversations and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.

7. Workforce

The topic of the workforce emerged from almost every discussion held as part of the planning process. The concept of workforce is used broadly in Connecticut with respect to children's behavioral health. It includes but is not limited to: Licensed behavioral health professionals; primary care providers; direct care staff across child-serving

systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support. Concerns related to workforce included: Shortages of key professionals or skills in the current workforce; lack of training capacity, including ongoing coaching, monitoring, and reinforcement in order to maintain skills; insufficient access to information for parents; and the lack of adequate knowledge among every sector of the workforce about children's behavioral health conditions and resources to address these conditions. Goals and strategies related to workforce development are reflected in 16 strategies across most of the thematic categories listed above.

As a result of the comprehensive process and extensive work done on Connecticut's Children Behavioral Health Plan described above, CT continues to utilize the plan as the driving blue print to enhance Connecticut system of care.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Children's Plan

Quality and Data Readiness Narrative
1. Briefly describe the state's data collection and reporting system and what level of data can be reported currently (e.g., at the client, program, provider, and/or other levels).

Behavioral health providers contracted by DCF report client-level data into an internet-based system known as the DCF Provider Information Exchange (PIE). Each contracted service (referred to as a Program) has its own customized data collection model, though many data elements are shared across Programs, in which data that is necessary to identify clients and their attributes, services delivered to the clients, and specified outcomes of service delivery.

Data is collected along a combination of points during service delivery, and for some Programs either/both during and after service delivery. Data can be collected on all referrals to a given Program, at Intake and Discharge, or periodically during the episode either at scheduled times for required Periodic Updates or on an as-needed basis for events called Activities.

Individual providers can choose to enter data into the system either directly through the website, or through monthly batch uploads or automated web services data transfers from internal database systems. A collection of data quality, performance management and outcome reports are built into the system, which also offers a data extraction utility for downloading customized datasets for additional analysis.

Access to the system is controlled through web-based security profiles, ensuring that users only have access to the data and information that their security profile allows. A wealth of training material is provided online in both written and short video formats, and a demonstration site is also available for training new users.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
Programs that submit data into the PIE system include substance abuse, mental health, in-home services, care coordination, and a variety of other child welfare services. Future releases will include the addition of other such services, as well as services to support juvenile justice populations. All such Programs are services contracted by CT DCF, but the clients receiving those services may or may not also be receiving other child welfare or juvenile justice services directly from the agency

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?
The PIE system and the DCF SACWIS system currently under development will give Connecticut added abilities to better capture the draft measures at the individual client

level. The children's statewide psychiatric hospital is currently upgrading their data system.

4. If not, what changes will the state need to make to be able to collect and report on these measures?
DCF has an annual allocation for maintenance and small enhancements in the PIE system.

Quality and Data Collection Readiness

1. **Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

   Connecticut Department of Mental Health and Addiction Services (DMHAS) allocate a portion of Block Grant funding to our sister agency, the CT Department of Children and Families (DCF). DMHAS reports both mental health and substance use TEDS data. DMHAS has reported substance abuse (SA) TEDS for a number of years. The adult service system collects client level data for all funded or operated mental health or substance abuse services. In addition, a state statute in CT requires non-funded SA providers to report admissions and discharges to DMHAS. DMHAS does collect data at each of the levels described above: client, program, and provider.

   DMHAS developed a data system to capture information from its private providers (DDaP) and uses a commercial system, WITS, to capture data from its state-run services. DDaP and WITS captures over 140 variables including NOMS, race and ethnicity, payor information, and contractually required performance measures. These data are then transferred for reporting purposes into an Enterprise Data warehouse (EDW). DMHAS is able to provide quarterly report cards for all funded and operated programs. The report cards include information related to consumer satisfaction, data quality, service utilization, National Outcome Measures (NOMS), and other contractually specified performance measures.

2. **Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collection and for what populations (e.g., Medicaid, child welfare, etc.)**

   As indicated above, the adult information systems only captures data from funded or operated mental health and substance abuse service providers. The exception is that DMHAS does collect information from non-funded licensed SA providers. Not all providers comply with this requirement but most do. Child welfare information is captured by DCF along with behavioral health data pertaining to their clients. Additional behavioral health data is collected by the state’s Medicaid authority (Department of Social Services - DSS). That information is available to DMHAS through a memorandum of agreement. That agreement specifies that DMHAS can access Medicaid claims data.

3. **Is the state currently able to collect and report on measures at the individual client level (that is, by client served, but not with client-identifying information)?**

DMHAS is capable of providing data at the individual level and is currently reporting TEDS data for both mental health and substance abuse.

4. **If not, what changes will the state need to make to be able to collect and report on these measures?**

   DCF, our sister agency that serves children would need to significantly upgrade their data collection systems. Data is not maintained in the same manner as the adult system (by client, program provider, level of care, and services) and would require significant upgrade to their current systems in order to report TEDS data.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Addressing the opioid crisis

Priority Type: SAT

Population(s): SMI, PWWDC, PWID

Goal of the priority area:

To expand use of Buprenorphine in outpatient clinics and local mental health authorities (LMHAs) across the service system.

Objective:

To provide training and technical assistance to outpatient and LMHA providers regarding the use of Buprenorphine for OUD.

Strategies to attain the objective:

Convene a learning collaborative for LMHA staff to provide training and technical assistance on the use of Buprenorphine; convene a learning collaborative for behavioral health outpatient clinics to incorporate Buprenorphine for treatment of OUD; provide DATA-waiver training to prescribers (MD, PA, and APRN) at LMHAs and Outpatients clinics.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of LMHAs prescribing Buprenorphine for clients with OUD

Baseline Measurement: 6

First-year target/outcome measurement: 25% increase in the number of LMHAs prescribing Buprenorphine for clients with OUD.

Second-year target/outcome measurement: 25% increase in the number of LMHAs prescribing Buprenorphine for clients with OUD.

Data Source:

DMHAS staff coordinating the learning collaborative with the LMHAs will collect data on the number of LMHAs prescribing Buprenorphine.

Description of Data:

Data will be collected by the DMHAS manager coordinating the learning collaborative.

Data issues/caveats that affect outcome measures::

Prescriber shortage-related concerns.

Priority #: 2

Priority Area: Supporting treatment on demand by providing transportation services

Priority Type:

Population(s): PWWDC, PWID

Goal of the priority area:

To improve responsiveness to those asking for treatment for substance use disorders.

Objective:

To increase timeliness of admission for those seeking and appropriate for a detoxification level of care.

Strategies to attain the objective:

Provide funding for transportation expansion; Contract with transportation providers; Educate staff answering the 1-800 number on process and available resources.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of rides provided to detoxification services

Baseline Measurement: 500 rides per year to detoxification

First-year target/outcome measurement: 600 rides per year to detoxification

Second-year target/outcome measurement: 700 rides per year to detoxification

Data Source:

Data will be collected by Advanced Behavioral Health (ABH- the administrative services organization) which manages transportation requests and deploys drivers.

Description of Data:

Data provided includes the number of calls to the 1-800 number, the number of rides provided, type of service the rider was delivered to, and location of service the rider was delivered to.

Data issues/caveats that affect outcome measures::

unanticipated budget reductions

Priority #: 3

Priority Area: Expanding recovery support services

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

To expand use of peer recovery coaches in EDs for persons presenting with substance use-related concerns.

Objective:

To connect substance users in EDs to treatment and/or support services.

Strategies to attain the objective:

Provide funding to the Connecticut Community for Addiction Recovery (CCAR) which oversees the recovery coaches; establish a formal agreement with the general hospitals for agreed upon services by the recovery coaches; train recovery coaches in recovery principles, engagement techniques, and available resources for patients; track calls received and outcomes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of general hospitals utilizing recovery coaches in their EDs.

Baseline Measurement: 4 hospitals

First-year target/outcome measurement: 8 hospitals

Second-year target/outcome measurement: 12 hospitals

Data Source:

CCAR collects data on the number of phone calls received from the hospital ED; the time between phone call and interaction of recovery coach with patient; whether client agreed to be connected to treatment and/or support and what the disposition was.

Description of Data:

Number of phone calls received from the hospital ED; the time between phone call and interaction of recovery coach with patients; whether client agreed to be connected to treatment and/or support and what the disposition was.

Data issues/caveats that affect outcome measures::

None identified.

Priority #: 4

Priority Area: Providing services to SMI clients to allow them to maintain a residence in the community

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To improve the quality of life and delivery of wrap around services for community-based SMI clients

Objective:

To increase fidelity scores of newly designated Community Support Programs (CSPs) and the lives of SMI clients receiving their services

Strategies to attain the objective:

Each new CSP will be required to participate in an ongoing monthly learning collaborative; service utilization, consumer satisfaction, and other data the programs submit will be reviewed, onsite consultation visits and training will be provided.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completed Fidelity Reviews

Baseline Measurement: to be established

First-year target/outcome measurement: all new CSP programs will have a completed baseline fidelity review

Second-year target/outcome measurement: all new CSP programs will demonstrate improved fidelity that exceeds their baseline level

Data Source:

Fidelity reviews are completed and maintained by the Evidence-Based Practices unit

Description of Data:

The CSP fidelity scale was created by DMHAS for this purpose and has been modified over time as needed.

Data issues/caveats that affect outcome measures::

None identified.

Indicator #: 2

Indicator: Outcomes measures (employment, social support, stable living and improved functioning)

Baseline Measurement: employment (goal 20%), social support (goal 60%), stable living (goal 80%) and improved functioning (goal 65%)

First-year target/outcome measurement: Three of the 4 outcomes will meet or exceed the goal

Second-year target/outcome measurement: 3 of the 4 outcomes will meet or exceed the goal

Data Source:

DMHAS routinely aggregates data submitted by programs and displays the data quarterly in a dashboard/report card format.

Description of Data:

Outcomes have been established for each level of care. For CSP, the following data are collected: treatment completion, stable living

situation, social support, employment status and maintained or improved functioning.

Data issues/caveats that affect outcome measures::

Timely submission of data by program staff.

Priority #: 5

Priority Area: To identify persons at risk for TB and refer as indicated for further services

Priority Type: SAT

Population(s): PWID, TB

Goal of the priority area:

To identify persons at risk for TB and refer as indicated for further services

Objective:

To educate infectious disease staff on the most current TB-related risk factors and guidelines.

Strategies to attain the objective:

Have the DPH TB officer for the state present the most current guidelines and risk factor information related to TB to the infectious disease staff at DMHAS programs; obtain a copy of the information presented and review it with all infectious disease staff.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of infectious disease programs whose staff has been educated on the most current TB-related risk factors and guidelines

Baseline Measurement: 0

First-year target/outcome measurement: 6 of the 9 programs will have staff educated on the most current TB-related risk factors and guidelines

Second-year target/outcome measurement: 9 of the 9 programs will have staff educated on the most current TB-related risk factors and guildelines

Data Source:

The DMHAS manager that oversees the infectious disease program staff and maintains all TB-related data.

Description of Data:

Attendance list as reported by the DMHAS manager that oversees infectious diseases at the programs.

Data issues/caveats that affect outcome measures::

None identified.

Priority #: 6

Priority Area: Childhood Trauma

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Ensure that children and youth in Connecticut (CT) who have experienced trauma, as well as their caregivers, receive effective treatment services to meet their needs. This includes ensuring that children and youth with less overt “developmental” trauma are identified and receive effective and comprehensive trauma treatment services.

Objective:

1. Increase the number of mental health agencies in CT that provide the evidence based “Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and/or Conduct Problems” (MATCH) for children, youth and their caregivers. MATCH is a mental health assessment and treatment model designed to deal with multiple problems and disorders encompassing anxiety, depression, posttraumatic stress, and conduct problems. Children and youth can initially present with anxiety, depression, or behavioral issues that belie underlying trauma. MATCH allows the flexibility to deal with both the overt and underlying cases of trauma. It is anticipated that MATCH can effectively serve up to 75% of CT children and youth who need mental health services

2. Increase the number of clinical staff trained in providing MATCH services to children, youth and their caregivers.

Strategies to attain the objective:

Strategies to attain the objective:
1. DCF, the Child Health and Development Institute of Connecticut (CHDI), and Harvard University (HU) have partnered to implement the MATCH model in CT through systems development and staff training.
2. Train clinical staff in outpatient clinics in the MATCH model.
3. MATCH dissemination will be facilitated through a Learning Collaborative (LC) implementation model that includes:
• Building providers’ capacity to implement MATCH with fidelity for youth through application of the LC methodology and the creation of a sustainable learning community;
• Developing collaborative and cooperative relationships between outpatient providers, clinicians, caregivers, and other community systems to assure effective referral, assessment, and treatment of children; and
• Building providers' capacity to utilize data and implement evidence-based practices through application of a LC methodology and the creation of a sustainable learning community.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of mental health agencies that provide MATCH for children, youth and their caregivers.
Baseline Measurement:	15 agencies trained in MATCH
First-year target/outcome measurement:	Train an additional 5 agencies in MATCH
Second-year target/outcome measurement:	Train an additional 5 agencies in MATCH

Data Source:

The Child Health and Development Institute of Connecticut (CHDI)

Description of Data:

CHDI will provide data on he numbers of agencies being trained to provide MATCH.

Data issues/caveats that affect outcome measures::

None

Indicator #:	2
Indicator:	Increase the number of clinical staff trained in providing MATCH services to children and youth.
Baseline Measurement:	Baseline of 100 clinicians trained in proving MATCH.
First-year target/outcome measurement:	Train an additional 25 clinicians in providing MATCH.
Second-year target/outcome measurement:	Train an additional 25 clinicians in providing MATCH.

Data Source:

The Child Health and Development Institute of Connecticut (CHDI)

Description of Data:

Report of actual numbers

Data issues/caveats that affect outcome measures::

none

Priority #: 7

Priority Area: Family Engagement

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase family voice

Objective:

To ensure that the voices, perspectives and input of family members are included in developing, planning, and overseeing the statewide children's behavioral health system.

Strategies to attain the objective:

a) Support Family System Managers (FSMs) positions at FAVOR
b) FSMs to recruit, train and support youth and families
c) Increase number of families that participate in committees, advisory bodies, policy reviews, and other venues

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increasing the number of families interfacing with the family system organization and then participating in follow up activities

Baseline Measurement: 5600 points of interface with families

First-year target/outcome measurement: 5700 points of interface with families

Second-year target/outcome measurement: 5800 points of interface with families

Data Source:

PIE (formally PSDCRS) and FAVOR reports

Description of Data:

Totals of participants at training, support groups and outreach activities

Data issues/caveats that affect outcome measures::

Integrity of PIE data source and other data tracking methods

Priority #: 8

Priority Area: Workforce Development

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To promote the development of a more informed and skilled workforce who have interest and solid preparation to enter positions that deliver evidence-based treatment programs.

Objective:

Increase the number of faculty and students trained in modules on EBP treatment at the graduate and undergraduate level to ensure students are exposed to best practices to make informed career an employment decisions

Strategies to attain the objective:

Strategy 1: Provide funding and other support to the Higher Education Partnership on Intensive Home-Based Services Workshop Development-Sustainability Initiative through contract with Wheeler Clinic.
Strategy 2: Expand the pool of faculty and programs credentialed to teach the Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut curriculum and promote accurate implementation of course content that is current and up-to-date.
Strategy 3: Maintain and promote teaching partnerships between higher education and providers delivering evidenced-based treatments through ongoing coordination and assignment of provider and client/family guest speakers for the curriculum

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain the number of faculty trained in the curriculum

Baseline Measurement: 32 faculty trained

First-year target/outcome measurement: 2 additional faculty trained due to attrtion

Second-year target/outcome measurement: 2 additional faculty trained due to attrition

Data Source:

Wheeler Clinic provider report

Description of Data:

Number of faculty trained and total number of faculty

Data issues/caveats that affect outcome measures::

Reduction in funding will reduce new additional faculty to be trained and may reduce the baseline

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Indicator #: 2

Indicator: Increase the number of students that receive certificates of completion

Baseline Measurement: 50 students received certificates

First-year target/outcome measurement: 60 students to receive certificates

Second-year target/outcome measurement: 65 students to receive certificates

Data Source:

Wheeler Clinic provider report

Description of Data:

Actual number of students who received certificates by completion of course and required certification process.

Data issues/caveats that affect outcome measures::

Reduction in funding in 2 year budget will reduce the number of students receiving certificates.

Priority #: 9

Priority Area: Prevention of mental illness

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Prevent and reduce attempted suicides and deaths by suicide among high risk populations.

Objective:

To enhance the knowledge base of youth, families, Department staff, providers and first responders regarding the prevention of youth suicide

Strategies to attain the objective:

Strategy 1. Implement awareness campaigns that include informational e-mails, a Department website, and suicide prevention brochures.
Strategy 2. Continue to engage in collaborative partnerships with DMHAS, schools, and first responder agencies to share delivery of the prevention training
Strategy 3 Use evidence-based curricula, ASIST, QPR and Safe Talk to train youth, families, Department staff, and first responder agency staff, through contracts with United Way and Wheeler Clinic.
Strategy 4. Use evidence-based curricula, Assessing and Managing Suicide Risk (AMSR) to train clinicians who deliver Emergency Mobile Psychiatric Services (EMPS).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Distribution of social marketing materials throughout the state of Connecticut

Baseline Measurement: 80,000 items distributed

First-year target/outcome measurement: 90,000 items distributed

Second-year target/outcome measurement: 100,000 items distributed

Data Source:

CT Suicide Advisory Board, United Way and Wheeler Clinic. Report the total number of outreach activities and numbers of suicide prevention materials disseminated

Description of Data:

Reports of actual numbers

Data issues/caveats that affect outcome measures::

none

Indicator #: 2

Indicator: Increase the number of individuals receiving suicide prevention/crisis response training

Baseline Measurement: 400 Individuals trained

First-year target/outcome measurement: 420 Individuals trained

Second-year target/outcome measurement: 430 Individuals trained

Data Source:

United Way and Wheeler Clinic. Report the total number of individuals

Description of Data:

Reports of actual numbers

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: ESMI interventon

Priority Type: MHS

Population(s): SMI, ESMI

Goal of the priority area:

Earlier identification and intervention for those with ESMI

Objective:

Earlier identification using ESMI outreach worker and Medicaid Claims data of any psychotic disorders in young persons. Continued utilization of the states' 2 evidence based program, POTENTIAL and STEP.

Strategies to attain the objective:

Beacon Health Options(ASO), through the ESMI ICM, will provide early identification of ESMI, rapid referral to evidence-based and appropriate services, and effective outreach engagement and coordination of care which are all essential to pre-empting the functional deterioration common in psychotic disorders.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of young persons identified with ESMI who agree to engage in treatment

Baseline Measurement: This is a new identification and referral system

First-year target/outcome measurement: 10% of young persons identified with ESMI will agree to engage in treatment.

Second-year target/outcome measurement: 15% of young persons identified with ESMI will agree to engage in treatment.

Data Source:

Beacon Health Options-ASO, POTENTIAL and STEP program

Description of Data:

Number of youth identified, referred and engaged in treatment

Data issues/caveats that affect outcome measures::

Refusals to engage by young persons and/or their caregivers.

Priority #: 11

Priority Area: Raising awareness of the risks of marijuana use among adolescents

Priority Type: SAP

Population(s): Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reducing marijuana use among 12-17 year olds

Objective:

Increase the percentage of 12-17 year olds perceiving marijuana as harmful.

Strategies to attain the objective:

Education

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of 12-17 year olds perceiving marijuana as harmful

Baseline Measurement: 21.8% (NSDUH 2013-2014)

First-year target/outcome measurement: 21.9%

Second-year target/outcome measurement: 22.0%

Data Source:

SAMHSA's National Survey on Drug Use and Health for Connecticut.

Description of Data:

The National Survey on Drug Use and Health is an annual survey in which about 67,000 Americans 12 and older who are non-institutionalized are interviewed to ask about their substance use practices.

Data issues/caveats that affect outcome measures::

None identified.

Indicator #: 2

Indicator: Percentage of parents (adults 26+) perceiving marijuana as harmful

Baseline Measurement: 28.1% (NSDUH 2013-2014)

First-year target/outcome measurement: 28.3%

Second-year target/outcome measurement: 28.5%

Data Source:

SAMHSA's National Survey on Drug Use and Health for Connecticut.

Description of Data:

The National Survey on Drug Use and Health is an annual survey in which about 67,000 Americans 12 and older who are non-institutionalized are interviewed about their substance use practices.

Data issues/caveats that affect outcome measures::

None identified.

Priority #: 12

Priority Area: Identifying Women's pregnancy intentions

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To ensure that women's preferences regarding reproduction are a component of her care.

Objective:

To increase the number of DMHAS programs that ask each women entering treatment what her intentions are regarding reproduction.

Strategies to attain the objective:

One Key Question is an evidence-based practice used to initiate conversations about preventive reproductive health in primary care. All women's programs will receive One Key Question training and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of programs trained in using One Key Question

Baseline Measurement: 0 programs have been trained in One Key Question.

First-year target/outcome measurement: 50% of DMHAS women's programs will be trained in One Key Question.

Second-year target/outcome measurement: 100% of DMHAS women's programs will be trained in One Key Question.

Data Source:

Records of training activities held through the Women's Services Practice Improvement Collaborative (WSPIC) and Every Woman CT training activities.

Description of Data:

WSPIC attendance records and minutes; Every Woman CT attendance records and minutes.

Data issues/caveats that affect outcome measures::

Providers are not always able to attend training due to the demands of their programs.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$29,017,588		$0	$8,139,292	$192,816,377	$0	$29,266,026
a. Pregnant Women and Women with Dependent Children**	$8,197,104		$0	$60,000	$4,406,130	$0	$1,517,840
b. All Other	$20,820,484		$0	$8,079,292	$188,410,247	$0	$27,748,186
2. Primary Prevention	$7,337,406		$0	$7,779,378	$7,732,414	$0	$2,553,642
a. Substance Abuse Primary Prevention	$7,337,406		$0	$7,779,378	$7,732,414	$0	$2,553,642
b. Mental Health Primary							
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$534,506	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$0		$0	$0	$21,285,864	$0	$0
10. SubTotal (1,2,3,4,9)	$29,017,588	$0	$0	$8,139,292	$214,636,747	$0	$29,266,026
11. SubTotal (5,6,7,8)	$0	$0	$0	$0	$0	$0	$0
12. Total	$36,354,994	$0	$0	$15,918,670	$222,369,161	$0	$31,819,668

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$822,724	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$489,313,094	$0	$5,951,256
7. Other 24 Hour Care		$422,646	$0	$38,350,292	$433,763,033	$0	$1,206,576
8. Ambulatory/Community Non-24 Hour Care		$6,951,860	$0	$12,021,594	$760,830,406	$0	$6,710,090
9. Administration (Excluding Program and Provider Level)		$30,000	$0	$0	$87,998,090	$0	$0
10. SubTotal (1,2,3,4,9)	$0	$30,000	$0	$0	$87,998,090	$0	$0
11. SubTotal (5,6,7,8)	$0	$8,197,230	$0	$50,371,886	$1,683,906,533	$0	$13,867,922
12. Total	$0	$8,227,230	$0	$50,371,886	$1,771,904,623	$0	$13,867,922

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women		
Women with Dependent Children		
Individuals with a co-occurring M/SUD		
Persons who inject drugs		
Persons experiencing homelessness		

Please provide an explanation for any data cells for which the stats does not have a data source.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$14,508,794
2 . Primary Substance Abuse Prevention	$3,668,703
3 . Early Intervention Services for HIV*	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	
6. Total	$18,177,497

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to

do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	$1,126,544
	Selective	$2,891
	Indicated	$26,825
	Unspecified	$0
	Total	$1,156,260
Education	Universal	$107,091
	Selective	$275
	Indicated	$2,550
	Unspecified	$0
	Total	$109,916
Alternatives	Universal	$90,054
	Selective	$231
	Indicated	$2,144
	Unspecified	$0
	Total	$92,429
Problem Identification and Referral	Universal	$6,606
	Selective	$17
	Indicated	$157
	Unspecified	$0
	Total	$6,780

Community-Based Process	Universal	$2,042,730
	Selective	$5,242
	Indicated	$48,641
	Unspecified	$0
	Total	$2,096,613
Environmental	Universal	$103,962
	Selective	$267
	Indicated	$2,476
	Unspecified	$0
	Total	$106,705
Section 1926 Tobacco	Universal	$97,430
	Selective	$250
	Indicated	$2,320
	Unspecified	$0
	Total	$100,000
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$0
Total Prevention Expenditures		$3,668,703
Total SABG Award*		$18,177,497
Planned Primary Prevention Percentage		20.18 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$2,965,780
Universal Indirect	$608,638
Selective	$9,171
Indicated	$85,114
Column Total	$3,668,703
Total SABG Award*	$18,177,497
Planned Primary Prevention Percentage	20.18 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBT	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$60,000		$84,480	
2. Infrastructure Support	$400,000			
3. Partnerships, community outreach, and needs assessment	$148,200		$588,922	
4. Planning Council Activities (MHBG required, SABG optional)	$15,000			
5. Quality Assurance and Improvement	$92,500			
6. Research and Evaluation	$0		$350,000	
7. Training and Education	$184,450		$350,000	
8. Total	$900,150	$0	$1,373,402	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:
CT views Respite as a direct service but added here based on examples.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   The state has been actively working to integrate mental health and primary health care. Several years ago, DMHAS initiated Behavioral Health Homes (BHHs) in 14 agencies across the state. This includes all of the Local Mental Health Authorities and two other private agencies. The BHHs are an innovative, integrated healthcare service delivery model that is recovery-oriented, person and family centered and promises better patient experience and better outcomes than those achieved in traditional services. The BHH service delivery model is an important option for providing a cost-effective, longitudinal "homes" to facilitate access to an inter-disciplinary array of behavioral health care, medical care, and community-based social services and supports for both adults and children with chronic conditions. The services are designed to achieve the Triple Aim of improving individual experience of care, improve population health, and reduce per capita health care costs. These services are funded by DMHAS and include care management and coordination, health and wellness activities, and referral to community support services. DMHAS serves approximately 10,000 individuals through these services annually.
   Integration also occurs outside of these BHHs. Various mental health providers across the state have developed relationships with local medical providers. In some instances the medical services are co-located at community mental health centers. This integration may also occur in other ways. Several LMHAs are Federally Qualified Health Centers (FQHCs) and deliver integrated services. In addition to these activities, DMHAS has applied for the Promoting Integration of Primary and Behavioral Health Care Integration Grant (PIPBHC). If DMHAS is awarded this grant, the funds would allow Connecticut to further expand our integration efforts.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   Connecticut has long recognized that mental health and substance use conditions often occur in the same individuals, consequently, DMHAS has been providing integrated services for co-occurring clients since the 1990s. Mental health and addiction treatment service providers continue to enhance their programming to provide integrated treatment for people with co-

occurring disorders. Specialized staff training, consultation, and pilot treatment projects for persons with co-occurring disorders have been put in place over the last twenty years to address the treatment needs of individuals with co-occurring disorders. The thirteen LMHAs have implemented the Integrated Dual Disorders Treatment (IDDT) model and addiction treatment providers have used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index to guide its integrated care for individuals with co-occurring disorders. Some mental health programs have also gravitated to using the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) instead of the IDDT model to guide their integration efforts. DMHAS created two co-occurring enhanced residential treatment programs that were procured in 2009 and continue today (primarily for quadrant III individuals) and a co-occurring enhanced inpatient unit that started in 2010 continues as well (primarily for quadrant IV individuals).
DMHAS contracted with an IDDT consultant from Dartmouth Medical School for 9 years (2002-2011) and with Dr. Mark McGovern (also from Dartmouth) for about 10 years to train and consult with DMHAS providers on the DDCAT. DMHAS also contracted with Yale (Dr. Michael Hoge and Scott Migdole, LCSW) to provide training and technical assistance to both mental health and addiction treatment agencies on a combined Co-Occurring and Supervision model for a couple of years.
Additionally, as part of the system change to ensure that mental health and substance use providers were considering all relevant conditions, DMHAS instituted a policy that all providers had to conduct co-occurring screenings at the time of admission and this process continues.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ○ No

   and Medicaid? ○ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   Access Health CT (AHCT) is responsible for monitoring access for plans sold on the exchange. The Office of the Health Care Advocate (OHA) monitors access through complaints received and the Clearinghouse. From a managed care perspective, the Connecticut Insurance Department (CID) has oversight over insurers' plan design, network, formulary and regulatory compliance for fully insured plans. The Connecticut Department of Labor's (DOL) Employee Benefits Security Administration regulates the remainder of the commercial plans.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ○ No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ○ Yes ○ No

   b) Health risks such as

      i) heart disease ○ Yes ○ No

      ii) hypertension ○ Yes ○ No

      viii) high cholesterol ○ Yes ○ No

      ix) diabetes ○ Yes ○ No

   c) Recovery supports ○ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   For the Medicaid population, Connecticut utilizes an Administrative Services Organization (ASO) designed to create an integrated behavioral health service system. Oversight of this ASO is an alliance among the Connecticut DMHAS, DSS (Medicaid authority) and DCF (Department of Children and Families), together creating the legislatively mandated Behavioral Health Partnership. The partnership works in conjunction to ensure parity for behavioral health services authorization and delivery. An example of an issue occurred about 2 years ago when authorization parameters for intermediate care for behavioral health services were changed to mirror the authorization parameters for medical health services, ensuring parity.
   As for non-Medicaid covered services, DMHAS has representation on a workgroup chaired by the Commissioner of the CT Insurance Department to review the practices of all payers in Connecticut.

10. Does the state have any activities related to this section that you would like to highlight?

    No.

    Please indicate areas of technical assistance needed related to this section

    None

Footnotes:

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

   a) Race — Yes / No

   b) Ethnicity — Yes / No

   c) Gender — Yes / No

   d) Sexual orientation — Yes / No

   e) Gender identity — Yes / No

   f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes / No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes / No

7. Does the state have any activities related to this section that you would like to highlight?

   Since 2003 there have been ongoing efforts to utilize the Office of Multicultural Healthcare Equality (OMHE) to identify and remediate disparities in behavioral health care. This process uses data from a variety of sources (DMHAS, Yale University and Beacon Health Options - DMHAS' ASO) and responds with targeted activities.
   Multicultural Enhancement Plan (MEP) is an initiative in which facilities are evaluated with respect to meeting CLAS standards. Results are analyzed and then reviewed with facilities which are then provided training and technical assistance to implement CLAS standards. The MEP initiative has focused on state-operated programs, but interested private nonprofits are welcome to participate.
   Multicultural Advisory Committee (MCAC) brings together state-operated regional facilities' multicultural councils statewide to strategize ways to enhance implementation of CLAS standards. Some of the activities that have occurred are community conversations about health disparities and "Chicago Dinners". These dinners have been held in each DMHAS region of the state and 2 locations (Waterbury and Norwich) have chosen to continue the dinners on an ongoing basis.

   Please indicate areas of technical assistance needed related to this section

   None.

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] http://psychiatryonline.org/

[57] http://store.samhsa.gov

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

   f) ☐ Quality measures focus on consumer outcomes rather than care processes.

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

   The child serving system has developed a robust Evidence Based Practice Service Array as highlighted in the narrative.

   Please indicate areas of technical assistance needed related to this section.

   None.

Footnotes:

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (•) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? (•) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

- outreach/engagement
- multidisciplinary team approach
- targeted services for young adults
- TOIVO: community-based program providing integrated whole person care focusing on wellness
- SBIRT
- TurningPointCT.org: website designed by/for young persons with mental health issues providing support and connection
- management of psychotropic medications
- CBT
- mobile crisis
- CIT: Crisis Intervention Team training of law enforcement on mental health issues and/or involvement of mental health personnel on crisis/911 calls
- supported education and vocational rehabilitation
- family education and support

Connecticut funds two programs designed to treat FEP: STEP program at CMHC/Yale in New Haven and the Potential Program at IOL/Hartford Hospital in Hartford. Each program provides targeted services for young people with FEP. The STEP program provides coordinated specialty care and the Potential program provides specialized services within a program treating young people with mental health issues.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive

individualized treatment or integrated mental and physical health services?

DMHAS has been supporting the DMHAS-operated and –funded mental health and addiction treatment providers in the use of the following evidence-based and best practices, including:
- Assertive Community Treatment (ACT)
- Integrated Treatment for Individuals with Co-Occurring Disorders
- DDCAT
- Dialectical Behavior Therapy (DBT)
- Supported Employment (SE) using Individual Placement and Support (IPS)
- Supported Education
- Supportive Housing
- Trauma-informed and Trauma-specific (and gender responsive) services
- Medication Assisted Treatment (MAT)
- Other EBPs, such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) are supported and embedded in several other EBPs (e.g., IDDT, DDCAT, and ACT) and other levels of care (e.g., outpatient, residential).

Alternative Services - An Integrative Medicine Committee was established at Connecticut Valley Hospital several years ago and more recently a statewide committee has been formed. There is increased emphasis in this area relative to the opioid crisis (e.g., alternative pain management strategies). A webpage was created on the DMHAS website documenting the committee's work and information on this topic: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=580236

DMHAS and Department of Children and Family (DCF) supports 2 programs (STEP and Potential) providing specialized FEP services.

DMHAS provides Young Adult Services (YAS) specially designed for young adults, most of whom are aging-out of DCF services into the adult system..

Alternative treatments and initiatives targeting Wellness have become more generally accepted and are providing opportunities for clients with mental health, substance use and co-occurring conditions to empower themselves by taking control of their own recovery. Healthy activities related to diet, exercise, meditation, etc. are offered in group settings which also provide an opportunity for positive social interactions and the forming of friendships with peers. Connecticut has TOIVO in Hartford and plans to expand into another such center underway. At TOIVO, people in recovery from mental health and substance use issues operate the programs and engage others in their activities which include yoga, mindfulness and other creative activities.

In FY 2011, DMHAS created an Evidence-Based (EB) and Best Practices Governance Committee. This committee continues to meet on a quarterly basis. The Governance Group consists of executive staff and Office of the Commissioner Division Directors. In 2010, DMHAS had designated a new position in the Office of the Commissioner: Director of Evidence-Based Practices (EBPs). This position provides staff support to the Governance Group along with other functions that promote the adoption of evidence-based practices throughout the system of care. Four managers report to the Director of EBPs, further enhancing the infrastructure necessary to complete the multiple and varied goals involving evidence-based and best practices in the DMHAS system. In 2015, this division also took on the federal grants coordination role, which includes leading the writing and submission effort for SAMHSA discretionary grants. These grants are often a vehicle for incorporating EBPs into the system.

The EBP Division created a series of webpages on the DMHAS website that describe different EBPs and various publications available to help implement the practices. This is a valuable resource for providers, consumers and families: http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=472912.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ( ) Yes ( ) No

5. Does the state collect data specifically related to ESMI? ( ) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ( ) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The following EBPs are being provided at one or both of the state's FEP programs:
- expert diagnostic assessment
- family education and support
- medication management
- social cognition intervention therapy (SCIT) based groups
- case management
- supported education and employment
- outreach and engagement

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Potential Program:
- FEP program will move into a dedicated space of its own
STEP Program:

- improve utilization of cognitive remediation treatment
- use personal therapy (PT) and cognitive enhancement therapy (CET) in a more efficient and disorder-specific manner
- work with Yale's PRIME clinic on a joint early detection model
- improve transitions to area clinics
- develop telecommunication models
-outreach activities to ESMI population
-using Medicaid Claims data, develop data reporting system for identification of any psychotic disorders

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

STEP completed the first US-based RCT in 2013 with NIH funding demonstrating the effectiveness of the approach.
Potential's comparison of admission and discharge BPRS found reductions in every symptom measure.
Both programs submit data to DMHAS on admissions, service hours, discharges, discharge status, and the National Outcome Measures including social support, stable living situation and employment status. Beyond this, each program collects different data. Potential measures BPRS at admission and discharge. STEP collects multiple data measures including Duration of Untreated Psychosis (DUP).
DCF and DMHAS are working with our ASO (Beacon Health Options) to analyze Meidciad Claims data for this population

10. Please list the diagnostic categories identified for your state's ESMI programs.

Schizophrenia
Schizophreniform
All primary psychotic illnesses in the schizophrenia spectrum

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? | Yes | No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. As of 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) are participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons are trained in person-centered planning by Yale PRCH.

4. Describe the person-centered planning process in your state.

   A Center for Medicare and Medicaid Services (CMS) grant awarded in 2009 provided a means to implement person-centered planning in Connecticut state-operated facilities. This process was extended to the Connecticut private nonprofit (PNP) sector as a component of developing the Community Support Program (CSP) and Assertive Community Treatment (ACT) teams. Ongoing fidelity reviews of the ACT and CSP teams in state-operated and PNP agencies include a focus on person-centered planning. As of 2014, all DMHAS PNP Local Mental Health Authorities (LMHAs) are participating in a multi-year federal Person-Centered Recovery Planning grant with the Yale Program on Recovery and Community Health (PRCH). LMHAs are receiving training and technical assistance to implement person-centered planning. At Connecticut Valley Hospital, the state-operated psychiatric hospital serving psychiatric, substance use and forensic clients, all clinical staff persons are trained in person-centered planning by Yale PRCH.

   Does the state have any activities related to this section that you would like to highlight?

   No.

   Please indicate areas of technical assistance needed related to this section.

   None.

Footnotes:

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   - Connecticut has already implemented person-centered treatment planning.
   - Connecticut undertook a year long project with Pat Deegan Associates for a Decision Support Learning Collaborative (DSLC) with 8 agencies which included training, technical assistance, and access/use of the Recovery Library.
   - A Recovery Support Specialist (RSS) Integration Learning Collaborative is underway in which DMHAS, in partnership with Yale Program on Recovery and Community Health (PRCH) recruited 10 behavioral health agencies in the fall of 2016 through an RFQ process to participate in the first RSS Integration Learning Collaborative. Drs. Chyrell Bellamy and Maria Restropo-Toro of PRCH are the lead faculty. They are leading the agencies through a year long process of improving their organizational cultures, policies and procedures to better integrate RSS into their workforces.

   Does the state have any activities related to this section that you would like to highlight?

   A Recovery Support Specialist (RSS) Integration Learning Collaborative is underway in which DMHAS, in partnership with Yale Program on Recovery and Community Health (PRCH) recruited 10 behavioral health agencies in the fall of 2016 through an RFQ process to participate in the first RSS Integration Learning Collaborative. Drs. Chyrell Bellamy and Maria Restropo-Toro of PRCH are the lead facility. They are leading the agencies through a year long process of improving their organizational cultures, policies and procedures to better integrate RSS into their workforces.

Please indicate areas of technical assistance needed to this section.

None.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed to this section

We don't believe we need technical assistance per se, but it would be beneficial for us to hear what best practices other states are using as far as state of the art block grant practices related to program integrity are concerned.

Footnotes:

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The DMHAS LMHA (local mental health authority) in the southeastern part of the state near the Mashantucket and Mohegan tribes continues to participate in regional coordinating/collaborative meetings with tribal leadership as part of the Regional Human Services Coordinating Council; the Southeastern Connecticut Health Improvement Collaborative; and the Emergency Management Committee. There has not been formal "consultation" provided.

2. What specific concerns were raised during the consultation session(s) noted above?

   The Mashantucket and Mohegan tribes continue to provide behavioral health services to their members who typically do not seek DMHAS services. However, ongoing efforts to coordinate and collaborate continue.

   Does the state have any activites related to this section that you would like to highlight?

   No.

   Please indicate areas of technical assistance needed to this section

   None.

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- *Information Dissemination* providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- *Education* aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- *Alternative programs* that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- *Problem Identification* and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- *Community-based Process* that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ( ) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ( ) Yes ( ) No

   - þ Data on consequences of substance using behaviors
   - þ Substance-using behaviors
   - þ Intervening variables (including risk and protective factors)
   - þ Others (please list)

   socio-demographics

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

   - þ Children (under age 12)
   - þ Youth (ages 12-17)
   - þ Young adults/college age (ages 18-26)
   - þ Adults (ages 27-54)
   - þ Older adults (age 55 and above)
   - þ Cultural/ethnic minorities
   - þ Sexual/gender minorities
   - þ Rural communities

- Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

- Biennial Community Readiness Survey
- Various Drug-Free Communities Surveys

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ( ) Yes ( ) No

If yes, (please explain)

Regional epidemiologic profiles containing prevention gaps and needs assessments are used to assess burden; identify regional community priorities; and capacity to address needs. The information in these profiles are used to inform development and procurement of prevention services.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section

None.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- *Environmental Strategies* that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (•) Yes ( ) No

   If yes, please describe

   Certification for prevention professionals is offered through the Connecticut Certification Board (CCB), an independent entity and member of the ICRC which promotes uniform professional standards and quality for the prevention and substance use counseling professional.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (•) Yes ( ) No

   If yes, please describe mechanism used

   The Training and Technical Assistance Service Center (TTASC) provides training on: The Strategic Prevention Framework, transfer and application of prevention research findings, cultural competence, and topics associated with prevention certification for the prevention workforce as identified in a Needs Assessment and subsequent Workforce Development and Training Plan. Technical Assistance is provided including more formalized assistance/consultation meetings of multiple prevention service providers as well as individualized assistance/consultation to providers in the areas of coalition building, evidence-based practices, policies and programs, and other areas as approved by the DMHAS Prevention and Health Promotion Unit.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (•) Yes ( ) No

   If yes, please describe mechanism used

   Every two years, a Community Readiness Survey is completed. The survey assesses each Connecticut town/city's readiness to prevent substance use problems among youth and adults by surveying selected community experts and key informants. The information gathered generates a prevention community readiness profile for towns/cities within Connecticut. The profiles are made available to members of each town/city represented and the data helps inform prevention planning, program development, and funding decisions. Data has also been used in the past to obtain additional funding and resources.

   Does the state have any activities related to this section that you would like to highlight?

   No.

   Please indicate areas of technical assistance needed related to this section

   None.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (j) Yes (j) No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   Live Healthy Connecticut: A Coordinated Chronic Disease Prevention and Health Promotion Plan, April 2014. This plan identifies ambitious, achievable and measurable objectives in each of 12 priority areas that address chronic disease with a focus on promoting health equity. The plan addresses root causes and shared risk factors across diseases, and defines strategies for a comprehensive proactive approach in modifying chronic disease risk factors. The 12 priority areas include: Health Equity; Nutrition & Physical Activity; Obesity; Tobacco; Heart Health; Cancer, Diabetes; Asthma; Oral Health; Genomics & Health; Health Care Quality; and Health Care Access. A comprehensive set of indicators track progress in each of these priority areas. The plan also establishes specific 5-year targets to promote accountability and engage partners around common objectives.

   Connecticut Safe Schools/Healthy Students (SSHS) Comprehensive Plan, September 2014. This plan was developed by the state substance use, mental health, juvenile justice, and education agencies in partnership with 3 local educational agencies (LEA) to address 5 elements of the federal initiative:
   1. Promoting early childhood social and emotional learning and development
   2. Promoting mental, emotional and behavioral health
   3. Connecting families, schools and communities
   4. Preventing behavioral health problems, including substance use
   5. Creating safe and violence-free schools

   The plan will: improve collaboration across all children, youth and family service organizations; implement evidence-based programs that reduce school violence and substance use and promote health; and promote wide scale adoption of the SSHS framework. The SSHS mission continues to be supporting school and community partnerships in their efforts to develop and coordinate integrated systems that create safe, drug-free, and respectful environments for learning and to promote the behavioral health of children and youth.

   The Connecticut Opioid REsponse (CORE) Initiative. This strategic plan addresses the issue of opioid use, addiction and overdose through a focused set of tactics and methods an evidence-based strategies with measurable and achievable outcomes for immediate deployment in order to have a rapid impact on the number of opioid overdose deaths in Connecticut.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (j) Yes (j) No (j) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds

b) Timelines

c) Roles and responsibilities

d) Process indicators

e) Outcome indicators

f) Cultural competence component

g) Sustainability component

h) Other (please list):

i) Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

This is currently under development.

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None.

Narratve Question

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) ☐ SSA staff directly implements primary prevention programs and strategies.

   b) ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).

   c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

   d) ☐ The SSA funds regional entities that provide training and technical assistance.

   e) ☐ The SSA funds regional entities to provide prevention services.

   f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.

   g) ☐ The SSA funds community coalitions to provide prevention services.

   h) ☐ The SSA funds individual programs that are not part of a larger community effort.

   i) ☐ The SSA directly funds other state agency prevention programs.

   j) ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:

   - media campaigns
   - brochures
   - health fairs
   - other health promotion (conferences, seminars)
   - speaking engagements
   - radio/TV public service announcements
   - curriculum dissemination

   b) Education:

   - peer leader/helper programs
   - ongoing classroom and/or small group sessions
   - parenting and family management

c) Alternatives:

- drug-free dances/parties
- youth/adult leadership activities
- community service activities
- community drop-in centers

d) Problem Identification and Referral:

- student assistance programs

e) Community-Based Processes:

- community and volunteer training (e.g., neighborhood action training
- impactor-training
- staff/officials training
- community team building
- technical assistance
- multi-agency coordination and collaboration/coalition
- accessing services and funding
- monitoring and evaluation
- systematic planning

f) Environmental:

- environmental consultation to communities
- promoting the establishment, enforcement and/or review of alcohol, tobacco and drug use laws and policies in schools and communities
- consultation to communities
- guidance and technical assistance on monitoring enforcement governing available and distribution of alcohol, tobacco and other drugs
- public policy efforts

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ( ) Yes ( ) No

If yes, please describe

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ☐ Yes ☐ No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

   a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   b) ☐ Includes evaluation information from sub-recipients
   c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
   d) ☐ Establishes a process for providing timely evaluation information to stakeholders
   e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   f) ☐ Other (please list:)

   g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) ☐ Numbers served
   b) ☐ Implementation fidelity
   c) ☐ Participant satisfaction
   d) ☐ Number of evidence based programs/practices/policies implemented
   e) ☐ Attendance
   f) ☐ Demographic information
   g) ☐ Other (please describe):

   - populations and services
   - prevention priorities
   - prevention expenditures

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☐ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☐ Heavy use

☐ Binge use

☐ Perception of harm

c) ☐ Disapproval of use

d) ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Note that these are pre-populated measures based on NSDUH reports for the state:
- age at first use
- perception of disapproval/attitudes
- social connectedness
- youth exposure to prevention messages

Footnotes:

Hyperlinks to attachments for Primary Prevention Narrative:

Live Healthy Connecticut: A Coordinated Chronic Disease Prevention and Health Promotion Plan. April 2014.

http://portal.ct.gov/-/media/Office-of-the-Governor/Press-Room/20161006-CORE-Initiative.pdf?la=en

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   - Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings.
   - Mobile emergency crisis services intervene in rapidly deteriorating behavioral health situations to decrease risk of harm to self/others, stabilize psychiatric symptoms, and divert as appropriate from inpatient stays
   - Crisis Intervention Team Training (CIT) trains law enforcement officers in responding to mental health emergencies so as to deescalate situations and access appropriate services; alternatively, mental health professionals may be asked to assist law enforcement in responding to behavioral health calls
   - Services provided to persons living in the community with mental health conditions to support their ability to continue to reside in the community

   For children with SED EMPS-Mobile Crisis Serviceis available 24 hours a day 365 days a year. Care Coordination and Intensive Care Coordination (over 85 FTEs) are available to all children in Connecticut to provide in-home, family driven services to prevent residential institutional care and hospitalization and/or reduce hospital and institutional care stays.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	Yes No
b)	Mental Health	Yes No
c)	Rehabilitation services	Yes No
d)	Employment services	Yes No
e)	Housing services	Yes No
f)	Educational Services	Yes No
g)	Substance misuse prevention and SUD treatment services	Yes No
h)	Medical and dental services	Yes No
i)	Support services	Yes No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes No
k)	Services for persons with co-occuring M/SUDs	Yes No

   Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

   Case management services are provided across a variety of levels of care within the DMHAS system. Persons with mental health conditions living in the community that receive supportive housing services, include case management that assists them with training, guidance and support to meet their needs and allow them to continue to reside in the community. Services provided are "wrap around" as needed to support the client. Case management is provided to homeless individuals in an attempt to engage them and have them willing to be connected to services. LMHAs provide case management services and strive to match clients

optimally to the level of care needed. The LMHAs meet with key stakeholders weekly to optimize client placement within the DMHAS system. Case management services are also typically provided within residential levels of care.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Local Mental Health Authorities (LMHAs) serve as gatekeepers to inpatient hospital beds and they hold weekly utilization review meetings
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Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	97,000	40,740
2.Children with SED	62,383	56,800

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Connecticut's statewide prevalence (active cases) of adults with SMI is from the Behavioral Health Barometer: Connecticut 2015 and represents 3.5% of adults.
Connecticut's statewide incidence (new cases) of adults with SMI is estimated to be 1.47% of adults, based on newly diagnosed cases within the Connecticut DMHAS system. Multiplying 1.47% by 2,755,642 Connecticut adults = 40,740.
List of SMI diagnoses is attached.
CT's SED prevalence rate is found by Utilizing the URS data from 2015 and the NRI table from November 2016.
The incidence rate is from the legislatively authorized DCF annual Behavioral Health Plan. DCF had previously used a prevalence rate of 7.1% but is now using 10%.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

DMHAS continues to examine the need, accessibility and availability of behavioral health services in rural areas. Past efforts to develop local systems of care has taken into account issues such as lack of transportation. As a result, many of the services provided in rural areas facilitate access through mobile capacity and satellite offices. DMHAS is a member of the Office of Rural Health (ORH). Recent collaboration on opioid use disorder resulted in increased capacity of 2 agencies serving rural communities. Connecticut ORH is a member of the Alcohol and Drug Policy Council.

In an effort to reduce the number of homeless individuals with SMI and co-occurring conditions, DMHAS established Homeless Outreach and Engagement Teams. These teams are in rural, suburban, and urban areas providing outreach, assessment, engagement, and case management services to homeless individuals. In addition to Homeless Outreach Teams, DMHAS created a network of social services and rental subsidy providers.

DMHAS' Long Term Services and Supports (LTSS) unit continues to broaden its statewide partnerships with providers of services to older adults. The LTSS Clinical Director attends the Office of Policy and Management's Long Term Care Planning Committee and co-chairs the Older Adult Workgroup with staff from the State Department on Aging. The Older Adult Workgroup is comprised of public and private providers of services to older adults. The Workgroup joined efforts with the University of Connecticut's Center on Aging to conduct a statewide assets mapping project to identify system strengths, needs, and service gaps. The project has been completed and results shared at the state capitol as well as disseminated to stakeholder groups throughout the state. The LTSS Clinical Director also chairs the Older Adult Workgroup Education and Training Subcommittee. As part of that subcommittee, partners from NAMI, Department of Social Services, and McCall Foundation are working to create on-line training products focusing on older adults for providers, consumers, and caregivers.

DMHAS LTSS currently manages the Senior Outreach Program that services older adults with substance use disorders and mental health needs. Seven private nonprofit agencies in Connecticut focus on outreach and engagement of older adults who are in need of treatment, but are not receiving services. Through the process of engagement, staff refer individuals to an appropriate level of care, including a weekly age-specific support group.

Another program that assesses for appropriate level of care is the Nursing Home Diversion and Transition Program (NHDTP). Through collaboration with DMHAS-funded agencies, the NHDTP was established with two goals: (1) to divert clients from nursing home placement unless absolutely necessary; and (2) to assist clients already in nursing homes to return to the community with ongoing support services. The NHDTP Nurse Clinicians and Case Manager work in conjunction with the state's Money Follows the Person Demonstration Project, and operate, in collaboration with the Medicaid Home and Community-Based Services (HCBS) Waiver for Persons with Mental Illness. Individuals who may not meet criteria for the waiver, or may not want wrap-around waiver services, may be served by the DMHAS NHDTP.

The three programs described above: The Medicaid HCBS Mental Health Waiver, The Nursing Home Diversion and Transition Program, and The Senior Outreach Program, identify individuals who are institutionalized or at risk of being institutionalized and attempt to provide them with the least restrictive setting for long-term care.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Block Grant funds are a relatively small part of DMHAS' budget for mental health/substance use prevention and treatment services. The entire continuum of care is supported by DMHAS whose target population are the medically indigent. Even with the ACA/Medicaid Expansion, there continue to be persons who are underinsured and, at least periodically, uninsured.
The Behavioral Health Planning Council conducts a priority setting process and annually evaluates the DMHAS system for strengths, needs/gaps and recommendations. This information is shared with DMHAS leadership for planning purposes and the state planner organizes this info into statewide report to inform the block grant application and priorities.
The results are also part of the annual DMHAS CMHS and SAPT Allocation Plans which describe how block grant funds will be spent. These plans require approval by the Connecticut Office of Planning and Management (OPM) prior to presentation to subcommittees of the state legislature which votes to approve and may request modifications.
Regular meetings are occur between DMHAS and DCF. Both state departments share CMHS block grant funds.

Footnotes:

List of SMI Diagnoses

Diagnosis	ICD-10 CM Code
Dementia in other diseases classified elsewhere with behavioral disturbances	F0281
Paranoid Schizophrenia	F200
Disorganized Schizophrenia	F201
Catatonic Schizophrenia	F202
Undifferentiated Schizophrenia	F203
Residual Schizophrenia	F205
Schizophreniform Disorder	F2081
Other Schizophrenia	F2089
Schizophrenia, Unspecified	F209
Schizotypal disorder	F21
Delusional disorders	F22
Schizoaffective disorder, bipolar type	F250
Schizoaffective disorder, depressive type	F251
Other Schizoaffective disorders	F258
Other psychotic disorder not due to a substance or known physiological condition	F28
Manic episode without psychotic symptoms, unspecified	F3010
Manic episode without psychotic symptoms, mild	F3011
Manic episode without psychotic symptoms, moderate	F3012
Manic episode, severe, without psychotic symptoms	F3013
Manic episode, severe, with psychotic symptoms	F302
Manic episode in partial remission	F303
Manic episode in full remission	F304
Other manic episodes	F308
Bipolar disorder, current episode hypomanic	F310
Bipolar disorder, current episode manic without psychotic features, mild	F3111
Bipolar disorder, current episode manic without psychotic features, moderate	F3112
Bipolar disorder, current episode manic without psychotic features, severe	F3113
Bipolar disorder, current episode manic, severe with psychotic features	F312
Bipolar disorder, current episode depressed, mild	F3131
Bipolar disorder, current episode depressed, moderate	F3132
Bipolar disorder, current episode depressed, severe, without psychotic features	F314
Bipolar disorder, current episode depressed, severe, with psychotic features	F315
Bipolar disorder, current episode mixed, mild	F3161
Bipolar disorder, current episode mixed, moderate	F3162
Bipolar disorder, current episode mixed, severe, without psychotic features	F3163
Bipolar disorder, current episode mixed, severe, with psychotic features	F3164
Bipolar disorder, in partial remission, most recent episode hypomanic	F3171
Bipolar disorder, in full remission, most recent episode hypomanic	F3172
Bipolar disorder, in partial remission, most recent episode manic	F3173
Bipolar disorder, in full remission, most recent episode manic	F3174
Bipolar disorder, in partial remission, most recent episode depressed	F3175
Bipolar disorder, in full remission, most recent episode depressed	F3176
Bipolar disorder, in partial remission, most recent episode mixed	F3177

Bipolar disorder, in full remission, most recent episode mixed	F3178
Bipolar II disorder	F3181
Other bipolar disorder	F3189
Major depressive disorder, single episode, mild	F320
Major depressive disorder, single episode, moderate	F321
Major depressive disorder, single episode, severe without psychotic features	F322
Major depressive disorder, single episode, severe with psychotic features	F323
Major depressive disorder, single episode, in partial remission	F324
Major depressive disorder, single episode, in full remission	F325
Other depressive episodes	F328
Other specified depressive episodes	F3289
Major depressive disorder, recurrent, mild	F330
Major depressive disorder, recurrent, moderate	F331
Major depressive disorder, recurrent, severe without psychotic features	F332
Major depressive disorder, recurrent, severe with psychotic features	F333
Major depressive disorder, recurrent, in remission, unspecified	F3340
Major depressive disorder, recurrent, in partial remission	F3341
Major depressive disorder, recurrent, in full remission	F3342
Other recurrent depressive disorders	F338
Major depressive disorder, recurrent, unspecified	F339
Cyclothymic Disorder	F340
Dysthymic Disorder	F341
Other persistent mood (affective) disorders	F348
Disruptive mood dysregulation disorder	F3481
Other specified persistent mood disorders	F3489
Agoraphobia with panic disorder	F4001
Agoraphobia without panic disorder	F4002
Social Phobia, generalized	F4011
Panic disorder without agoraphobia	F410
Generalized Anxiety Disorder	F411
Other mixed anxiety disorders	F413
Other specified anxiety disorders	F418
Obsessive-Compulsive Disorder	F42
Mixed obsessional thoughts and acts	F422
Hoarding disorder	F423
Other obsessive-compulsive disorder	F428
Post-traumatic Stress Disorder, acute	F4311
Post-traumatic Stress Disorder, chronic	F4312
Dissociative amnesia	F440
Dissociative fugue	F441
Dissociative stupor	F442
Conversion disorder with motor symptom or deficit	F444
Conversion disorder with seizures or convulsions	F445
Conversion disorder with sensory symptom or deficit	F446
Conversion disorder with mixed symptom presentation	F447
Dissociative identity disorder	F4481

Other dissociative and conversion disorders	F4489
Anorexia Nervosa, restricting type	F5001
Anorexia Nervosa, binge eating/purging type	F5002
Bulimia Nervosa	F502
Other eating disorders	F508
Binge eating disorder	F5081
Other specified eating disorder	F5089
Puerperal psychosis	F53
Paranoid Personality Disorder	F600
Schizoid Personality Disorder	F601
Antisocial Personality Disorder	F602
Borderline Personality Disorder	F603
Obsessive Compulsive Personality Disorder	F605
Pathological Gambling	F630
Pyromania	F631
Intermittent explosive disorder	F6381
Fetishism	F650
Transvestic fetishism	F651
Exhibitionism	F652
Voyeurism	F653
Pedophilia	F654
Sexual masochism	F6551
Sexual sadism	F6552
Frotteurism	F6581
Other paraphilias	F6589
Factitious disorder with predominant psychotic signs and symptoms	F6811
Factitious disorder with combined psychotic and physiological signs and symptoms	F6813

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	Yes No
ii)	Education	Yes No
iii)	Brief Intervention	Yes No
iv)	Assessment	Yes No
v)	Detox (inpatient/social)	Yes No
vi)	Outpatient	Yes No
vii)	Intensive Outpatient	Yes No
viii)	Inpatient/Residential	Yes No
ix)	Aftercare; Recovery support	Yes No

b) Are you considering any of the following:

	Targeted services for veterans	Yes No
	Expansion of services for:	
(1)	Adolescents	Yes No
(2)	Other Adults	Yes No
(3)	Medication-Assisted Treatment (MAT)	Yes No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ( ) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? ( ) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ( ) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? ( ) Yes ( ) No

5 Are you considering any of the following:

a) Open assessment and intake scheduling ( ) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes ( ) No

c) Expanded community network for supportive services and healthcare ( ) Yes ( ) No

d) Inclusion of recovery support services ( ) Yes ( ) No

e) Health navigators to assist clients with community linkages ( ) Yes ( ) No

f) Expanded capability for family services, relationship restoration, custody issue ( ) Yes ( ) No

g) Providing employment assistance ( ) Yes ( ) No

h) Providing transportation to and from services ( ) Yes ( ) No

i) Educational assistance ( ) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Since 2010, DMHAS revised its Priority Access and Interim Services protocol to improve access and ensure quality of care. While all SAPT-funded programs continue to follow the same protocol in terms of ensuring Priority Access and Interim Services for women within 48 hours of requesting treatment, the department instituted a centralized referral line for providers to manage placement and capacity issues. All priority calls are routed to the centralized phone number at Beacon Health Options, the department's ASO, where calls are tracked and care coordination monitored. If Beacon cannot obtain timely treatment for the woman, the DMHAS Women's Administrator or her designee are contacted to ensure timely access to care or interim services arranged. Beacon produces quarterly reports including number of calls received and outcomes. Enhancements to care include trauma-informed and gender-responsive fidelity reviews and learning collaboratives.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

   a) 90 percent capacity reporting requirement — Yes / No

   b) 14-120 day performance requirement with provision of interim services — Yes / No

   c) Outreach activities — Yes / No

   d) Syringe services programs — Yes / No

   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation — Yes / No

2. Are you considering any of the following:

   a) Electronic system with alert when 90 percent capacity is reached — Yes / No

   b) Automatic reminder system associated with 14-120 day performance requirement — Yes / No

   c) Use of peer recovery supports to maintain contact and support — Yes / No

   d) Service expansion to specific populations (military families, veterans, adolescents, older adults) — Yes / No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Community Services Division (CSD) of DMHAS is responsible for monitoring all clinical and recovery support providers with DMHAS contracts to ensure that the delivery of quality services that are appropriate to the needs of the service recipients are in compliance with DMHAS policies and contracts and facilitate the development of a publicly managed, integrated behavioral health system of care. CSD staff work closely with other DMHAS units to assure a complete picture of provider performance is developed. This includes EQMI (Evaluation, Quality Management & Improvement) to develop reports and other tools for monitoring and oversight activities and to identify additional information for analysis of contract performance. It also includes the Human Services Contract Unit regarding fiscal concerns. They collaborate with the Statewide Services Unit (SSD) when reviewing women's services, senior services, housing, problem gambling, and prevention services. CSD staff also collaborate with the Office of Multicultural Healthcare Equality (OMHE) to monitor and review the cultural competence of services and environments and to address behavioral health care disparities. Monitoring activities vary in intensity and impact on the agency. When a performance issues is identified, CSD will evaluate the significance of the issue and determine the appropriate course of action. Responses range from requesting a corrective action plan to a site visit. Monitoring occurs across all behavioral health services funded by DMHAS and incorporates activities of varying intensity dependent upon provider compliance, including focused and comprehensive site visits. Both routine and non-routine monitoring occur. Routine monitoring visits are based on when a program was last reviewed, outcome performance and modality performance. Contracts describe the scope of work purchased by DMHAS, performance requirements that identify expectations for activities and interventions, and models of service to be delivered. Specific performance outcomes are also identified. Routine monitoring includes: data analysis/provider quality report reviews, CEO/provider meetings, site visits, fidelity reviews for evidence-based practices, and CAP compliance. An on-site monitoring visit may be triggered by: critical incident, complaint, DPH finding, fiscal irregularity, etc. All on-site visits generate a findings report.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — Yes / No

2. Are you considering any of the following:

   a) Business agreement/MOU with primary healthcare providers — Yes / No

   b) Cooperative agreement/MOU with public health entity for testing and treatment — Yes / No

   c) Established co-located SUD professionals within FQHCs — Yes / No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and

corrective actions required to address identified problems.

Programs are required to submit data quarterly related to TB including: number of TB tests conducted, number of persons referred for confirmatory testing, number who complied with confirmatory appointment and the actual number of positive results. DMHAS conducts quarterly meetings with infectious disease providers.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes ( ) No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes ( ) No

   b) Establishment or expansion of tele-health and social media support services ( ) Yes ( ) No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ( ) Yes ( ) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ( ) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ( ) Yes ( ) No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ( ) Yes ( ) No

   If yes, plese provide a brief description of the elements and the arrangement

   Syringe Services in Connecticut are provided by the Department of Public Health, not DMHAS. Some substance use treatment programs that receive DMHAS funding do work closely with the syringe services programs in different locales around the state.

Criterion 8,9&10

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — Yes / No

2. Are you considering any of the following:

   a) Workforce development efforts to expand service access — Yes / No

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — Yes / No

   c) Establish a peer recovery support network to assist in filling the gaps — Yes / No

   d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — Yes / No

   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — Yes / No

   f) Explore expansion of service for:

      i) MAT — Yes / No

      ii) Tele-Health — Yes / No

      iii) Social Media Outreach — Yes / No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — Yes / No

2. Are you considering any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — Yes / No

   b) Establish a program to provide trauma-informed care — Yes / No

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — Yes / No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — Yes / No

2. Are you considering any of the following:

   a) Notice to Program Beneficiaries — Yes / No

   b) Develop an organized referral system to identify alternative providers — Yes / No

   a) Develop a system to maintain a list of referrals made by religious organizations — Yes / No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes / No

2. Are you considering any of the following:

   a) Review and update of screening and assessment instruments — Yes / No

   b) Review of current levels of care to determine changes or additions — Yes / No

c) Identify workforce needs to expand service capabilities — Yes / No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes / No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes / No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — Yes / No

b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes / No

c) Updating written procedures which regulate and control access to records — Yes / No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — Yes / No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes / No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

50

3. Are you considering any of the following:

a) Development of a quality improvement plan — Yes / No

b) Establishment of policies and procedures related to independent peer review — Yes / No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — Yes / No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — Yes / No

If YES, please identify the accreditation organization(s)

i) Commission on the Accreditation of Rehabilitation Facilities

ii) The Joint Commission

iii) Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No

2. Are you considering any of the following:

   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No

   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

   a) Recent trends in substance use disorders in the state Yes No

   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No

   c) Preformance-based accountability Yes No

   d) Data collection and reporting requirements Yes No

2. Are you considering any of the following:

   a) A comprehensive review of the current training schedule and identification of additional training needs Yes No

   b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No

   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No

   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

   a) Allocations regarding women Yes No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

   a) Tuberculosis Yes No

   b) Early Intervention Services Regarding HIV Yes No

3. Additional Agreements

   a) Improvement of Process for Appropriate Referrals for Treatment Yes No

   b) Professional Development Yes No

   c) Coordination of Various Activities and Services Yes No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ( ) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

   Each year DMHAS recruits, through an RFQ process, a cohort of 4 agencies to participate in a 2-year change process designed to help them become more trauma-informed and gender-responsive. Programs that are more trauma-informed and gender-responsive are expected to be more successful at both engaging clients in the recovery process and at preventing their re-traumatization. Selected agencies receive baseline and follow-up services including:
   - trauma and gender fidelity reviews
   - training
   - consultation
   - "mystery shopper walk through" in which Advocacy Unlimited is contracted to conduct unannounced evaluative intake/admission sessions to assess, from a peer's perspective, how trauma-informed and gender-responsive the agency's intake process is.

- "report out days" when the selected programs are convened every 6 months throughout the 2-year change process to "report out" their progress, lessons learned, and challenges; and
- site visits conducted periodically by contracted consultants which provide real-time feedback and a written fidelity review report provided to the program.
DMHAS graduated its last cohort in May 2017. They are now in the process of designing a new regional learning collaborative process to be co-facilitated by DMHAS and the Women's Consortium to help agencies continue to become more trauma-informed and gender-responsive. Implementation of this new model is slated for Fall 2017.

DCF as a trauma informed agency funds annual training through the Child Health and Development Institute to train all providers on being a trauma informed serve array. DCF has been addressing trauma informed practice through policies and practices for a number of years.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

[63] http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   The 21st century CARES act-Opioid STR grant provided funds to DMHAS, some of which will be used to support Department of Correction (DOC), Court Support Services Division (CSSD) and local police efforts. DOC, DMHAS, DCP and community providers are working together to maintain incarcerated clients on methadone. Efforts are underway to expand this to more prisons. Efforts are also underway to educate DOC employees about naloxone use and some inmates are now being discharged with narcan kits.

   "Second Chance" is a Governor lead and legislative supported initiative which helps to reduce prison populations and ensures nonviolent offenders are successfully reintegrated into society and become productive workers in Connecticut's economy, by emphasizing treatment and rehabilitation over punishment for non-violent drug crimes.

   Legislation also funds additional program expansion of vocational and job-based adult education, employment training, School-Based Diversion Initiative (SBDI) initiatives to reduce suspensions, expulsions, and school-based arrests, and supportive housing services for frequent users of substance abuse and individuals with mental health issues that cycle in and out of the corrections system. Reintegration units have been established for woman, youth and veterans for a focus on rehabilitation.

DCF for SED youth has focused attention on implementing the closing the Connecticut Juvenile Training School and developed a comprehensive juvenile justice diversion plan.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No

   a) Methadone
   b) Buprenophine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   - DMHAS conducts on-site monitoring of all methadone clinics.
   - There is a Learning Collaborative conducted quarterly with all the methadone clinics.
   - Federal discretionary grants awarded will use some of the funds for increasing access to Buprenorphine, naltrexone and naloxone.

   Please indicate areas of technical assistance needed to this section.

   None.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) þ Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) þ Psychiatric Advance Directives
   - c) þ Family Engagement
   - d) þ Safety Planning
   - e) þ Peer-Operated Warm Lines
   - f) é Peer-Run Crisis Respite Programs
   - g) þ Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) é Assessment/Triage (Living Room Model)
   - b) é Open Dialogue
   - c) þ Crisis Residential/Respite
   - d) þ Crisis Intervention Team/Law Enforcement
   - e) þ Mobile Crisis Outreach
   - f) þ Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) é WRAP Post-Crisis
   - b) þ Peer Support/Peer Bridges

c) ☐ Follow-up Outreach and Support

d) ☐ Family to Family Engagement

e) ☐ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☐ Follow-up crisis engagement with families and involved community members

g) ☐ Recovery community coaches/peer recovery coaches

h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

DMHAS received a SAMHSA BRSS TACS grant (bringing recovery supports to scale) related to introducing more peers into the DMHAS crisis system. Technical assistance is completed. The group of stakeholders involved has expanded and continues to move the process forward. Partner include Connecticut Community for Addiction Recovery (CCAR), Connecticut Alliance to Benefit Law Enforcement (CABLE - which conducts CIT training), North Central Regional Mental Health Board, members of private nonprofit programs and state-operated mobile crisis teams, etc.

Community Conversations are occurring with faith based groups. The Community Conversations promote healing, recovery and healthy communities and encourage participants to learn and share from others' experiences. Topics covered in this 6-part series include: accessing care for mental health and substance use, identifying new strategies for outreach and support, and strengthening partnerships between mental health and substance use providers, individuals, families in recovery, faith community leaders and law enforcement.

Hartford Communities that Care is a local organization conducting training for volunteers to respond to neighborhood violence and trauma. The goal of the non-clinical crisis response and neighborhood support training is to offer residents, members of the faith community, grassroots and front-line community members the basic skills needed to provide effective support to violent crime victims and their families. Its a 5-part training series in the community.

For SED youth, CT has a robust EMPS-Mobile Crisis response system that is available 24 hours a day 365 days a year for all Connecticut youth in behavioral health crisis. Crisis clinicians are required to be response within 45 minutes of the call. Last year's statewide average was 24 minutes for a face to face crisis assessment.

Please indicate areas of technical assistance needed to this section.

None.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

   b) Required peer accreditation or certification? ( ) Yes ( ) No

   c) Block grant funding of recovery support services. ( ) Yes ( ) No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

   Yes. There is a peer workforce advisory board created in 2014. The Recovery Advisory Board assists DMHAS to promote a recovery-oriented system of care. Also, the Director of Recovery Consumer Affairs is a member of the DMHAS Commissioner's Executive Group.
   Connecticut established a definition of recovery and recovery values in 2003. In October 2012, grassroots stakeholder groups and advocacy organizations were asked to review the general principles and guidelines to see if updating was needed. There was consensus that the definition and core values remain relevant and inclusive. Below are links to DMHAS Commissioner Statements regarding a recovery-oriented system for Connecticut:
   http://www.ct.gov/dmhas/lib/dmhas/policies/chapter6.14.pdf
   http://www.ct.gov/dmhas/lib/dmhas/recovery/tenets.pdf
   http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=335078

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Connecticut offers many components for peer support, coaching, education about alternative approaches to healing and recovery, as well as self-management for individuals served and family support, warm lines, supported employment, Recovery Centers, Peer Bridging, Certified Recovery Support Specialists (MI) and Certified Recovery Coaches (SA).
   In March 2014, DMHAS implemented a Commissioner's Policy Statement on supporting the creation of Advance Directives. Since then, DMHAS has collaborated with the Connecticut Legal Rights Project (CLRP) to train more than 80 staff in DMHAS programs statewide to assist individuals in completing the Advance Directives workbook and following the process to completion of an executed Advance Directive.
   As part of the Recovery University, the DMHAS funded training academy for Recovery Support Specialists managed by Advocacy Unlimited, training is offered in specific ways to provide peer support services to military veterans, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others.
   In 2014, DMHAS launched the Hearing Voices Network. As part of this initiative, five international trainers in the Hearing Voices approach and the Maastricht Interview Technique were brought together with voice hearers, family members, professionals and the public. The centerpiece of the initiative has been the training of certified Hearing Voices Network support group facilitators and the creation of a network of peer-run community-based support groups for voice hearers.
   Requests for Proposals (RFPs) are not only scored in a manner which gives increased weight/points to those demonstrating involvement of persons in recovery and their families, but persons in recovery are also involved in the awards process. Regional Mental Health Boards, which have strong representation of persons in recovery, provide evaluation and ongoing dialogue with DMHAS leadership through a variety of forums on service design and strategic planning. Satisfaction and other evaluative tools are used for ongoing quality improvement.
   The manager at the Office of the Commissioner that is responsible for Recovery Community Affairs is a liaison to agency leadership providing ongoing input from grassroots advocacy organizations and programming.
   DMHAS contracted with Pat Deegan Associates (PDA) to conduct a year-long Decision Support Learning Collaborative with eight agencies. The project included training, technical assistance and the use of PDA's web-based recovery library.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   CCAR operates three recovery community centers (Bridgeport, Windham and Hartford) which offer a place to go and spend time with others in recovery from substance use, participate in 12-step meetings, and participate in other group activities. CCAR operates a Telephone Recovery Support program in which persons in recovery call others early in their recovery who are requesting the support. Assistance may also be provided in the form of transportation to self-help support meetings, information about available resources, etc. CCAR initiated a new program in March 2017 which involves 4 local hospital EDs contacting a CCAR trained Recovery Coach when they have a patient present with a substance-related issue (such as overdose). The Recovery Coach

attempts to engage the patient and get them to take the next step toward recovery.
Another recovery activity related to the current opioid epidemic is the "Gone but not forgotten Quilt Project" which celebrated its first event in January 2017. Family members and significant others of persons who have died as a result of substance use are offered the opportunity to make a quilt square in memory of the loved one they lost to substances. The events are being held around the state and they provide an opportunity to raise awareness and reduce stigma.

5. Does the state have any activities that it would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   - housing services provided. ( ) Yes ( ) No
   - home and community based services. ( ) Yes ( ) No
   - peer support services. ( ) Yes ( ) No
   - employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   In 2011, the DMHAS Commissioner issued a departmental policy statement, Accessibility to Services, Programs, Facilities and Activities, which outlines the requirements of facilities in regard to their responsibilities pursuant to Title II of the Americans with Disabilities Act and section 504 of the Rehabilitation Act. All state-operated and contracted agencies are required to meet these requirements. The policy can be found at: http://www.ct.gov/dmhas/lib/dmhas/policies/chapter2.20.pdf

   Does the state have any activities related to this section that you would like to highlight?

   No.

   Please indicate areas of technical assistance needed related to this section.

   None.

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   - a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No
   - b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
   - a) Child welfare? ( ) Yes ( ) No
   - b) Juvenile justice? ( ) Yes ( ) No
   - c) Education? ( ) Yes ( ) No
3. Does the state monitor its progress and effectiveness, around:
   - a) Service utilization? ( ) Yes ( ) No
   - b) Costs? ( ) Yes ( ) No
   - c) Outcomes for children and youth services? ( ) Yes ( ) No
4. Does the state provide training in evidence-based:
   - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No
   - b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No
5. Does the state have plans for transitioning children and youth receiving services:
   - a) to the adult behavioral health system? ( ) Yes ( ) No
   - b) for youth in foster care? ( ) Yes ( ) No
6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   Currently, Connecticut is near completion of year three of a four year System of Care grant. This is the third System of Care Grant DCF has received. Although we are working towards a fully integrated approach, CT still has eleven different state department which share part of the role for the Behavioral Health System.. CT has partially implemented a "Care Management Entity" (CME) - approach to allow for full integration of the behavioral health system. CT has hopes of implementing a more complete CME-approach for improved, integrated behavioral health care.
7. Does the state have any activities related to this section that you would like to highlight?

   DCF is committed to integration in infrastructure and development of the behavioral health system. To this end, through the federal System of Care CONNECT grant, seven work groups have been formed to facilitate this process. They include Fiscal Analysis and Mapping, Network of Care Analysis, Data Integration, Workforce Development, Communication, Family and Youth Engagement, and Implementation of the National CLAS Standards (and racial justice activities).

   Please indicate areas of technical assistance needed related to this section.

   None.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

   The Zero Suicide Learning Collaborative (ZSLC) was established 10.8.15 under the Connecticut Suicide Advisory Board. ZSLC has 6 systems adopting the Zero Suicide approach and the Garrett Lee Smith (CLS) youth suicide prevention grant intensive community-based effort is managed by CHR (Community Health Resources). All have a care transitions component.

   Additionally, the CT Suicide Prevention Plan 2020, is discussed frequently at the CT Suicide Advisory Board (CTSAB) monthly meetings. Suicide prevention activities are prioritized and guided routinely by the CT Suicide Prevention Plan and the CTSAB members.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? Yes No

   If so, please describe the population targeted.

   In CT, DMHAS, DCF and DPH received applied for and recieved the Garrett Lee Smith (GLS) grant begining in September 2015. Through the GLS CT initiated the Zero Suicide Learning Collaborative (ZSLC) in October of 2015. The GLS is funded until October 2020 and the ZSLC is ongoing. CT is prioritizing the development of regional networks of care for suicide prevention, intervention and response based on the five DMHAS regions. There is an intensive community-based effort focused on Manchester area youth ages 10-24 based on a statewide evaluation of youth ages 15-19 on suicide mortality and hospitalization data. The evaluation is available at: http://www.sciencedirect.com/science/article/pii/S1054139X17301106,
   CT through the GLS grant is currently conducting a statewide needs assessment of key stakeholders and developing regional magnitude and severity profiles for suicidal behavior. Combined, the results will help prioritize high need areas for strategic planning and implementation of evidence-based practices.

   Does the state have any activities related to this section that you would like to highlight?

   No.

   Please indicate areas of technical assistance needed related to this section.

   None.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

   If yes, with whom?

   N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

   DMHAS partners with a number of other state agencies in the process of fulfilling its mission. Many clients receive services across state agencies or transition between departments as their needs dictate. Communication and coordination among these state agencies, therefore, is critical to providing efficient and effective care. The cross agency programming and prevention efforts on behalf of these shared clients not only provides better integrated care, but also helps to reduce the likelihood of such adverse outcomes as recidivism, institutionalization, and homelessness.
   Close collaboration with the Department of Children and Families (DCF) must exist as DMHAS shares 30% of its CMHS block grant allocation with DCF to provide services to children. Those children and adolescents under age 18 receiving behavioral health services from DCF may ultimately require transition to the adult system operated by DMHAS. DMHAS has services specifically for young adults (young adult services or YAS) ages 18-26. Both departments jointly plan all aspects of the transition, communicate regularly concerning the referral, identify and resolve any issues which arise, and provide ongoing operational support. DMHAS and DCF serve together on the Connecticut Behavioral Health Partnership (CT BHP) to further develop an integrated behavioral health system for Medicaid eligible children and adults. DMHAS' Adult Behavioral Health Planning Council and DCF's Children's Behavioral Health Advisory Council come together as the Joint Behavioral Health Planning Council for the purpose of fulfilling

block grant related responsibilities. The joint meeting of these two councils provides opportunities for sharing common concerns and collaborating on common efforts.

The Department of Social Services (DSS) likewise serves with DCF and DMHAS on the CT BHP. Further, DSS works with both departments on a number of other efforts. With DCF, DSS works collaboratively to identify strategies and resources to advance evidence-based treatments for children and families and to improve access, quality and outcomes of interventions. With DMHAS, DSS supports integration of primary and behavioral health care in outpatient clinics, Behavioral Health Homes, and works collaboratively through the Mental Health Home and Community Based Medicaid Waiver to return nursing home residents with psychiatric illnesses to their communities.

With a focus on the needs of older adults, Connecticut's State Department on Aging (SDA) collaborates with DMHAS on the Older Adult Behavioral Health Workgroup toward an integrated and multidisciplinary behavioral health care system that improves the health, wellness and recovery of older adults.

The Department of Public Health (DPH) partner with both DMHAS and DCF to work collaboratively to promote integration and coordination of behavioral health and primary care services among federally qualified health centers and community mental health providers; supports efforts to identify health disparities of both physical and behavioral health services and build awareness and compel action to address such disparities; support activities to strengthen school-based health clinics; support implementation of a medical home model of care; and promote quality behavioral health services through routine sharing of licensing and other quality review reports with DMHAS staff; and coordinate licensing rules and regulations for child-serving agencies.

The Department of Housing (DOH) and the Connecticut Housing Finance Authority (CHFA) collaborate with DMHAS in efforts to increase the availability of supportive housing for those who are homeless and have a mental illness or co-occurring mental illness and substance use disorder. DOH, CHFA and DMHAS join with other agency partners through the Interagency Council on Supportive Housing and Homelessness to expand access to permanent supportive housing.

The Court Support Services Division (CSSD) shares many of the same clients and client concerns as DMHAS and DCF. Together, DCF and CSSD work to strengthen and better integrate the shared service network and initiatives for youth and to share blended funding for certain evidence-based treatment for young people and their families. DMHAS and CSSD collaborate on jail diversion for adults and continue to fund and manage two programs for criminal justice involved adults with mental illness and/or co-occurring disorders. The Department of Correction (DOC), in their work with adult criminal justice clients, collaborates with DMHAS by continuing to refer to DMHAS all discharging sentenced inmates with a serious mental illness, supporting Re-entry Counselors in their work with offenders discharged from DOC custody to connect them with behavioral health and related support services, participates in monthly interagency meetings to resolve system issues, and continues to support the Advanced Supervision Intervention and Support Team (ASIST) initiative designed to increase the number of persons with behavioral health issues who are diverted or released early from jail or prison by providing multiagency supports in the community.

The Alcohol and Drug Policy Council (ADPC) was directed by the Governor's Office to take on new membership (including people in recovery from substance use and their family members) and to focus on the Opioid Epidemic. The ADPC is co-chaired by the Commissioners of DMHAS and DCF and includes representation from state legislators as well as all the state agencies involved in responding to the opioid epidemic, including Consumer Protection, Aging, Education, Public Health, Emergency Services and Public Protection, Corrections, etc. There are three active subcommittees of the ADPC: Prevention, Treatment and Recovery. Activities and recommendations originating in the subcommittees are brought forward to the ADPC and have resulted in successful passage of legislation targeting various aspects of addressing the opioid crisis, education for prescribers and consumers, public service announcements to raise public awareness, etc.

Legislation in late 2015 on children's behavioral health added additional state agencies in sharing the responsibility of children's behavioral health in CT; they include the Department of Developmental Services, State Department of Education, Connecticut Insurance Department, Office of Early Childhood, Office of the Child Advocate, Office of the Healthcare Advocate and the Commission on Women, Children and Seniors.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

CONNECTICUT HOUSING FINANCE AUTHORITY

March 22, 2017

The Honorable Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

The Connecticut Housing Finance Authority (CHFA) supports Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment block grant application. CHFA will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS), assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS, in collaboration with state and community partners, proposes to promote community integration and inclusion through the provision of permanent housing for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder.

CHFA, as a collaborative partner, will assist DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the individuals that DMHAS serves. CHFA will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness. Our goal is to expand access to permanent supportive housing and increase the affordable housing stock by providing funding opportunities for supportive housing development projects throughout the state.

CHFA supports the state's block grant application and looks forward to continuing to work with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Karl F. Kilduff
Executive Director

DEPARTMENT of CHILDREN and FAMILIES
Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

March 16, 2017

The Honorable Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment block grant application. The Department of Children and Families (DCF) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) to assist in the implementation of priorities identified in the grant application for those with mental illness.

Specific activities that the DCF will support include:

- Continuing our strategic partnership with DMHAS to assist with implementing priorities that are identified in the 2018-2019 application. The primary purpose of this collaboration is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.
- Participating in the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for Medicaid eligible children and adults.
- Facilitating the coordination of services between DMHAS and DCF for clients who are under the care of DCF (committed or voluntary) or who are eligible for services through DMHAS. Specific activities will include: joint planning of all aspects of transition services; regular communication to monitor the referral process; identification and resolution of issues; and ongoing operational support.

DCF looks forward to advancing Connecticut's agenda to establish a comprehensive and effective community-based mental health system of care. Thank you for this opportunity to continue our strong collaboration in this area.

Sincerely,

Joette Katz
Commissioner

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STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

MIRIAM E. DELPHIN-RITTMON, Ph.D.
COMMISSIONER

March 17, 2017

The Honorable Joette Katz, JD
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, Connecticut 06106

Dear Commissioner Katz:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Connecticut Department of Mental Health and Addiction Services (DMHAS) will continue its strong partnership with the Department of Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to and quality of behavioral health services for those with a serious emotional disturbance or a mental or substance use disorder.

The focus of our shard work is to facilitate the coordination of services between DCF and DMHAS for clients who are under the care of DCF (committed or voluntary) or who are eligible for services through DMHAS. Specific activities will include: joint planning of transition services for those DCF-involved youth aging into the adult behavioral health system; regular communication to monitor the referral process for this population, and identify and resolve issues as they arise; and lastly, to continue our ongoing alliance to assure a smooth transition for youth and young adults so that they receive the very best care.

Additionally, DMHAS looks forward to continuing such collaborative efforts as the joint initiative on suicide prevention.

DMHAS looks forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Sincerely,

Miriam Delphin-Rittmon

Miriam E. Delphin-Rittmon, Ph.D.
Commissioner

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STATE OF CONNECTICUT
DEPARTMENT OF CORRECTION

OFFICE OF THE COMMISSIONER

Dannel P. Malloy
Governor

Scott Semple
Commissioner

April 3, 2017

The Honorable Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, Connecticut 06134

Dear Commissioner Delphin-Rittmon:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment block grant application. The Department of Correction (DOC) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) to assist with the implementation of priorities that are identified in the application regarding the criminal justice population. The primary purpose of this collaboration is to improve access to and the quality of behavioral health and support services for adults with moderate to serious mental illness and/or substance use disorders.

Specific activities that the DOC will support include:
1. Continuing to refer to DMHAS all discharging sentenced inmates with serious mental illness (SMI);
2. Supporting Reentry Counselors in their work with offenders being discharged from DOC custody to connect them to resources that may include medical services, mental health and/or substance use services, criminal risk factor treatment, housing, employment, necessary identification papers, and governmental entitlements;
3. Participating in monthly interagency meetings that include Correctional Mental Health Care staff, Probation, Board of Pardons and Paroles, and DMHAS Local Mental Health Authorities to resolve system issues that impact continuity of care, focusing on complex cases that require special coordination of all agencies; and
4. Continuing to support the Advance Supervision Intervention and Support Team (ASIST) initiative targeted to individuals with a moderate to severe psychiatric disability. This effort is designed to increase the number of individuals with psychiatric disorders who are diverted from jail or released early from jail or prison providing multi-agency support to improve their success in the community and reduce recidivism and re-incarceration.

I and the DOC staff look forward to working in partnership with DMHAS to promote a comprehensive and effective community-based system of care for persons who are criminally-involved and in need of behavioral health and support services.

Sincerely,

Scott Semple
Commissioner

SS/jab

Phone: 860.692.7482 ◆ Fax: 860.692.7483
24 Wolcott Hill Road ◆ Wethersfield, Connecticut 06109

Dannel P. Malloy
Governor

STATE OF CONNECTICUT
DEPARTMENT OF HOUSING

Evonne M. Klein
Commissioner

March 16, 2017

The Honorable Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon,

The Department of Housing (DOH) supports Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. DOH will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS), assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders. DMHAS, in collaboration with state and community partners, proposes to promote community integration and inclusion for persons who are homeless and have a mental illness or co-occurring mental illness and substance use disorder through the provision of permanent housing.

DOH, as a collaborative partner, will assist DMHAS in its efforts to increase the availability of supportive housing in order to meet the demand for permanent housing for the DMHAS population. DOH will continue to work with DMHAS and its interagency partners through the Interagency Council on Supportive Housing and Homelessness to expand access to permanent supportive housing by assisting in the financing of supportive housing development projects.

DOH looks forward to working with DMHAS and its interagency partners in support of efforts to expand Connecticut's affordable housing infrastructure.

Sincerely,

Evonne M. Klein
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

March 16, 2017

The Honorable Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

The Honorable Joette Katz, JD
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

I am pleased to provide this letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Public Health (DPH) will continue and strengthen its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to, and the quality of, behavioral health services, as well as the primary healthcare needs of those with a serious emotional disturbance or a mental or substance use disorder.

In partnership with DMHAS and DCF, DPH will:
1. Work collaboratively to promote integration and coordination of behavioral health and primary care services among Federally Qualified Health Centers and community mental health providers;
2. Support efforts to identify health disparities relating to both physical and behavioral health services and build awareness of and compel action to address such disparities;
3. Support activities to strengthen existing school-based health clinics;
4. Support implementation of a medical home model of care; and
5. Promote quality behavioral health services through routine sharing of licensing and other quality review reports with DMHAS staff, and coordinate licensing rules and regulations for child-serving agencies.

DPH looks forward to advancing a statewide agenda for a comprehensive, effective, community-based system of behavioral and primary healthcare.

Sincerely,

Raul Pino, MD, MPH
Commissioner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

RODERICK L. BREMBY
Commissioner

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June 16, 2017

The Honorable Miriam Delphin-Rittmon, Ph.D.
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

The Honorable Joette Katz, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioner Delphin-Rittmon and Commissioner Katz:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Department of Social Services (DSS) will continue its strategic partnership with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to and the quality of behavioral health services for those with a serious emotional disturbance or mental or substance use disorder.

Specific activities supported to DSS include:

- Work collaboratively with DCF and DMHAS to support strategies of prevention and early identification of individuals with behavioral health conditions
- Continuing its participation in and support of the Connecticut Behavioral Health Partnership to further develop an integrated behavioral health system for the Medicaid eligible population.
- Working collaboratively to identify strategies and resources to advance evidence-based child/family treatments.
- Improving access, quality and child/family outcomes through ongoing collaboration.
- Continuing support for outpatient clinics to focus on integrated primary care and treatment for persons with co-occurring mental health and substance use disorders.

DSS looks forward to advancing the agenda for a comprehensive, effective community-based system of care for those with a behavioral health disorder.

Sincerely,

Roderick L. Bremby
Commissioner

STATE DEPARTMENT ON AGING
– Growing Older Together –

55 Farmington Avenue
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Email: aging.sda@ct.gov

March 16, 2017

Miriam Delphin-Rittmon, Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

Dear Commissioner Delphin-Rittmon:

The Connecticut State Department of Aging (SDA) supports Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. SDA will continue its partnership with the Department of Mental Health and Addiction Services (DMHAS) assisting in the implementation of priorities identified in the grant application for adults with serious mental illness and/or substance use disorders.

With a focus on the needs of Connecticut's older adults, SDA will continue to collaborate with DMHAS on the Older Adult Behavioral Health workgroup, whose mission is to strive toward an accessible, integrated, multi-disciplinary system of behavioral health care services that promote improved health, wellness and recovery for older adults in Connecticut.

SDA looks forward to advancing the agenda for a comprehensive, effective, community-based system of care for those with behavioral health disorders.

Sincerely,

Elizabeth B. Ritter
Commissioner

State of Connecticut

JUDICIAL BRANCH

OFFICE OF THE CHIEF COURT ADMINISTRATOR
COURT SUPPORT SERVICES DIVISION
936 Silas Deane Highway, Wethersfield, CT 06109

June 5, 2017

The Honorable Miriam Delphin-Rittmon, Ph.D.
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

The Honorable Joette Katz, Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 combined Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grant application. The Judicial Branch Court Support Services Division (CSSD) will continue its strategic partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Children and Families (DCF) to assist with the implementation of priorities identified in the state's block grant application. The primary purpose of this collaboration is to improve access to and the quality of behavioral health and support services for adults and children with moderate to serious mental illness and/or substance use disorders.

In partnership with DMHAS and DCF, CSSD will:

1. Continue to strengthen the shared service network developed for those youth that are involved with the child welfare and juvenile justice systems;
2. Continue to share blended funding for the delivery of certain evidence-based treatments such as multi-systemic family therapy and intensive in-home child and adolescent psychiatric services;
3. Collaborate on state and federally-funded initiatives to better integrate care for youth that are involved with the child welfare and juvenile justice systems;
4. Continue to fund and manage with DMHAS two programs for adults with mental illness and/or co-occurring disorders, including the Sierra Pretrial Program, a transitional housing facility to pretrial defendants, and the Advanced Supervision and Intervention Support Team (ASIST) program which combines criminal justice supervision with clinical services for pretrial defendants and probationers a risk of violation.

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An Equal Opportunity / Affirmative Action Employer

We look forward to advancing a statewide agenda for a comprehensive, effective community-based system for juveniles and adults who are court-involved and in need of behavioral health treatment and support services.

Sincerely,

Gary A. Roberge
Acting Executive Director

STATE OF CONNECTICUT
STATE BOARD OF EDUCATION

June 9, 2017

The Honorable Joette Katz, Commissioner
Connecticut Department of Children and Families
505 Hudson Street
Hartford, Connecticut 06106

Dear Commissioner Katz:

On behalf of the Connecticut State Department of Education (CSDE), I am pleased to provide a letter of support for Connecticut's FY 2017-2018 Community Mental Health Services Block Grant application.

We will continue our strategic partnership with the Connecticut Department of Children and Families (DCF) to assist with the implementation of priorities that are identified in the Children's State Plan. The primary purpose of our collaboration is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.

CSDE, in partnership with DCF and the Court Support Services Division (CSSD) of the Judicial Branch, will continue to work collaboratively on school-based diversion of children involved in both child welfare and juvenile justice systems by intervening around mental health crises that might otherwise lead to arrest. Additionally, we will continue to support DCF's school-based suicide prevention and mental health promotion activities that support Connecticut's children and families.

We look forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Sincerely,

Dianna R. Wentzell

Dr. Dianna R. Wentzell
Commissioner of Education

State of Connecticut
Department of Developmental Services

Dannel P. Malloy
Governor

Jordan A. Scheff
Commissioner

June 16, 2017

Joette Katz, Commissioner
Connecticut Department of Children and Families
505 Hudson Street
Hartford, Connecticut 06106

Dear Commissioner Katz:

I am pleased to provide a letter of support for Connecticut's FY 2018-2019 Community Mental Health Services Block Grant application. We will continue our strategic partnership with the Department of Children and Families (DCF) to assist with the implementation of priorities that are identified in the Children's State Plan. The primary purpose of our collaboration is to improve access to and quality of behavioral health services for children and adolescents with mental illness and their families.

The focus of our interagency work is the coordination of services between DCF and the Department of Developmental Services (DDS) for clients who are either involved with both DCF and DDS or may be eligible for Voluntary Services through DSS. Joint planning activities will include: service model and resource development; workforce training and coordination; transition and service planning; fiscal and legal matters; and practice and program evaluation.

We look forward to advancing the statewide agenda for a comprehensive, effective community-based system of care.

Very truly yours,

Jordan A. Scheff
Commissioner

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460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov

July 31, 2017

Miriam Delphin-Rittmon, PhD
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th floor
Hartford, CT 06134

Joette Katz, JD
Commissioner
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Dear Commissioners Delphin-Rittmon and Katz,

The Behavioral Health Planning Council has been involved throughout the various stages of the planning, development, and review of the Block Grant Application. For example, updates are provided at each Council meeting on all block grant related activities. Such updates include information on webinars, technical assistance opportunities, SAMHSA initiatives, budget concerns, progress with respect to block grant priorities, pending report/application requirements, revisions, and deadlines. Time is allowed for discussion and questions; and, Council members may ask for additional information and request copies of documents which are either provided in hard copy or emailed.

Biannually, the Council identifies needs/problems and strengths of the service system; and develops recommendations through the Regional Priority Setting Process. A statewide summary of findings was developed this past fiscal year and results were presented to the Council and others. Additionally, the Council was involved to a greater degree than previous years in understanding and being involved in the priority selection process for the block grant application.

The 2018-2019 Combined CMHS/SAPT Block Grant Application and Plan has been presented to the Council during recent Council meetings, and we have had an opportunity to ask questions and make recommendations. As a result, the Council endorses Connecticut's 2018-2019 Block Grant Application and Plan with comments and recommendations included.

Sincerely,

Marcia DuFore
Adult Council Chair

Doriana Vicedomini
Child Council Co-Chair

Janice Bendall
Child Council Co-Chair

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The Department of Mental Health and Addiction Services, as the name implies, has been a single integrated department since 1995, servicing all behavioral health needs of adults. Connecticut has been submitting combined Mental Health and Substance Abuse block grant applications since 14/15. The biannual priority setting process is likewise integrated to cover mental health, substance use and co-occurring populations and services.

   In October 2012, the State Mental Health Planning Council was expanded to encompass substance use services and was renamed the State Behavioral Health Planning Council. Also at this time, membership was expanded to key stakeholders from the addiction system, including persons in recovery from addiction, family members of persons in recovery from addiction, and advocates and providers of substance abuse treatment prevention services. Membership was also extended to include the DMHAS Director of Prevention and Health Promotion.
   Council membership includes representation from substance use providers, advocates, and persons in recovery. When council members have been surveyed, a significant proportion consider themselves advocates for substance use as well as mental health. Orientation for new Council members typically occurs annually and reinforces that the Council purview encompasses substance use concerns. The biannual Priority Setting Process includes questions related to substance use, mental health, and co-occurring populations/services and recommendations resulting from this process address all of these areas. The State Planner for the Adult portion has a background of more than 25 years working in Addiction Treatment. Updates and presentations to the Council include all manner of behavioral health concerns.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ( ) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes ( ) No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   Children's Behavioral Health Planning Council (CMHPC): Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) to the State Advisory Council on Children and Families (SAC) to "promote and enhance the provision of behavioral health services for all children" in Connecticut. The CBHAC serves as the state's Children's Mental Health Planning

Council (CMHPC) as required by PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state's System of Care for children and families.
The 32-member CBHAC/CMHPC is comprised of the Commissioners of Children and Families, Social Services, Protection and Advocacy, Education, Mental Health and Addiction Services, Developmental Services, or their respective designees; two Gubernatorial appointments, six members appointed by the leadership of the General Assembly, as well as sixteen members appointed by the chairperson of the SAC. The membership composition of the advisory committee is designed to fairly and adequately represent parents of children who have a serious emotional disturbance. "At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." In addition, a parent is to serve as co-chair of the CBHAC/CMHPC. CBHAC meetings held throughout the year include time for review of the MHBG. Meetings held in the fall delineate spending plans and planning for the following year. This includes an open forum for questions. CBHAC membership reviewed designated priorities and provided input into the development of this plan on January 6, 2017, March 3, 2017 and June 2, 2017.

The Behavioral Health Planning Council is required under the Federal Public Health Services Act and the Community Mental Health Services Block Grant. The Council duties include:
• To review the Combined CMHS and SAPT Block Grant Application and State Plan provided to the Council by the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), and to submit to the Commissioners of those departments any recommendations of the Council for modification to those plans;
• To serve as an advocate for adults with SMI, and children with SED and their families, as well as other individuals with mental illness or emotional problems; and
• To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services in Connecticut.

Council representation includes state agencies, other public and private entities concerned with the need, planning, operation, funding and use of mental health and related services, family members of adults and children with SEDs, and representatives of organizations of individuals with mental illness and/or substance use and their families, and community groups advocating on their behalf.

Council business since the last block grant submission included reviewing the priority setting process and the role of the planning council, prompted by attendance by the adult and child council chairs as part of the Connecticut team at the SAMHSA block grant conference in August 2016. Information about activities conducted by some other state councils resulted in a re-consideration of the potential activities of the Connecticut planning council. Also, presentations on a variety of behavioral health topics have occurred (such as by one of the two FEP programs in the state (one had to be rescheduled for November 2017)) or are scheduled: Zero Suicide for September 2017, One Key Question for October 2017, and the rescheduled STEP program (FEP) for November 2017.

The Regional Mental Health Boards (RMHBs) and the Regional Action Councils (RACs) which participate in the Adult Behavioral Health Planning Council were instrumental in conducting the 2016 Priority Setting Process (see the Behavioral Health Needs Assessment section for more details). The RMHBs and RACs used information from DMHAS- provided regional client profiles and an on-line survey of providers as a starting point from which to conduct their focus groups and "community conversations" to gain qualitative feedback about the behavioral health service system. The RMHBs and RACs combined this data with information garnered from other sources, such as local hospital and school survey data, comments and feedback from meetings with community stakeholders, public forums, evaluations, and interviews, etc., to produce regional priority setting reports. These regional reports were presented to DMHAS leadership and the Behavioral Health Planning Council. Regional reports were organized by the state planner into a single statewide priority setting report which informed the priority setting of the block grant application. Through this approach, the Council plays a vital role of determining the direction of the Block Grant.

Does the state have any activities related to this section that you would like to highlight?

DCF staff, the co chair of CBHAC and the executive director of the statewide family organization all participated in state TA to State Planning Council on Family Advocacy Meetings. Each month slides from the webinar were shared during the CBHAC monthly meeting.
Inclusion of the Adult and Child Chairs of the Planning Council in the SAMHSA block grant conference in August 2016 as part of the Connecticut team generated much enthusiasm and subsequent sharing of information and discussion within the planning council meetings as to its role and possible activities. This has led to discussions about how the Planning council can be more effective and involved in moving behavioral health forward in the state.

Please indicate areas of technical assistance needed related to this section.

None.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

2016 REPORT ON STATEWIDE PRIORITY SERVICES

January 26, 2017

2016 Statewide Priority Setting Report

Priority Setting Process:

DMHAS' priority setting initiative, designed to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state, began in December 2001. Fundamental to this process are Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) which are statutorily charged to determine local and regional needs and service gaps. Both of these entities, working collaboratively, facilitate a process in each of the five DMHAS regions to assess the priority unmet service and recovery support needs across the mental health and addiction service systems. Since inception in 2006, DMHAS has conducted its priority setting process every other year (in even-numbered years). In the intervening years (odd-numbered years), the RMHBs and RACs provide updates to inform DMHAS of progress made in addressing the identified unmet needs and to alert the department to any emerging issues. As part of this process, RMHBs and RACs use aggregate profile data provided by DMHAS to describe usage of services within their region, provider survey results based on an on-line survey asking for responses about the DMHAS service system, and other sources of information from local needs assessments/surveys and activities. Armed with this information, RMHBs and RACs orchestrate key informant constituency groups (consumers/persons in recovery, family members, providers, referral agencies such as shelters and criminal justice representatives, and local professionals, law enforcement, and town officials) to participate in community conversations, focus groups, and/or structured interview sessions asking about service system barriers, gaps, and concerns. This process results in Regional Priority Reports across the behavioral health continuum. These reports are presented to DMHAS leadership at regional meetings, providing an opportunity for dialogue between the department and regional stakeholders. From the regional reports, a synthesized statewide priority report is created that examines cross regional priorities and solutions. The statewide report is shared and discussed with the Adult State Behavioral Health Planning Council and the Commissioner. DMHAS is indebted to the RMHBs and RACs for their ongoing efforts on behalf of the behavioral health needs of the citizens of Connecticut. Their passion and commitment are evident as they continuously strive to better the lives of persons living with mental health and substance use conditions.

It should be noted that some of the concerns identified in this report exist outside of DMHAS' purview. Matters related to other state agencies or private entities are duly noted, but will not be addressed by DMHAS. Other issues, such as transportation or housing concerns, while beyond DMHAS' ability to manage independently, are topics related to larger behavioral health issues statewide which DMHAS attempts to address jointly in ongoing efforts with other state agencies. Further, there are federal regulations governing the use of block grant funds within which DMHAS must operate. A new feature of this report is the inclusion of DMHAS activities related to identified areas of concern. While there may not be a response for every concern raised, in many instances there are activities ongoing or planned which the reader of the report may have been unaware of.

State Profile of Services:

The number of unduplicated clients served in FY 2016 was 112,864 comprised of 61,341 clients treated in substance use services and 59,225 clients treated in mental health services (including 7,702 clients receiving both). The greatest numbers of clients served came from the most populated regions. There were 107,212 admissions, 60,703 for substance use and 46,509 for mental health. To access the Annual Statistical Report: http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2016.pdf.

Demographics of DMHAS clients SFY 2016

	Substance Use	Mental Health	Total
Female	30.4%	51.3%	40.6%
Male	68.6%	48.6%	58.9%
White/Caucasian	65.5%	62.6%	64.0%
Black/African American	13.6%	17.4%	15.7%
Other or missing race	21.0%	20.0%	20.5%
Hispanic/Latino	21.4%	19.5%	20.4%
Non-Hispanic	71.0%	74.5%	72.9%
Unknown ethnicity	7.7%	5.9%	6.7%
18 - 25	17.3%	11.9%	14.4%
26 - 34	29.1%	16.4%	23.0%
35 - 44	20.5%	16.5%	18.8%
45 - 54	18.6%	23.5%	21.4%
55 - 64	10.4%	21.5%	15.7%
65+	2.3%	9.2%	5.4%
Unknown age	1.8%	1.0%	1.3%

While males and females are almost evenly divided in mental health services, in substance use programs, two-thirds of the clients are male. Most clients served in the DMHAS system are white/Caucasian (64%) while the July 1, 2015 census data finds that 81% of Connecticut residents are white/Caucasian. Ostensibly it appears that white/Caucasian clients are underrepresented and black/African American clients are overrepresented in the DMHAS treatment population; however, the category "other or missing race" is sufficiently large to caution against such a conclusion. Similarly, Hispanic/Latino clients comprise 15.4% of Connecticut's population based on census data and are 20.4% of the DMHAS treatment population. Finally, as to age, clients in substance use services tend to be younger than clients receiving mental health services.

For clients receiving mental health services, the primary diagnostic categories are major depression (18.2%), schizophrenic disorder (12.5%), and bipolar disorder (10.4%). When examining primary and non-primary diagnoses, just over half of the clients qualify for an SMI (Serious mental illness) diagnosis, which involves having one or more of the following: schizophrenia (and related disorders), bipolar disorder, and/or major depression. It is interesting to note that two out of three (68%) of all clients (mental health and substance use) have a substance use diagnosis. This is the first year in which heroin has been reported more frequently than alcohol across total new admissions. For clients admitted to substance use services, primary drug use was reported as heroin/other opioids (46.0%) followed by alcohol (33.9%) and marijuana (10.0%).

Most clients in both systems of care participated in outpatient treatment, followed by residential and then inpatient, as can be seen from the table below.

Levels of Care	Substance Use	Mental Health
Outpatient	55,256	58,387
Residential	11,323	2,922
Inpatient	2,717	1,428

With respect to young adults in SFY 2016, DMHAS Young Adult Services (YAS) served 1,225 clients, which represents 7.5% of the total 18 – 25 year old population served by DMHAS (16,235) and reflects a 3.5% increase over the number served in YAS in SFY 2015. YAS serves clients aged 18 – 25 with a history of DCF involvement and major mental health problems.

Structure for Evaluation:

As budgets were tightening, each state agency was required to identify their core functions so a prioritization process with respect to what would be funded could be established. The result of DMHAS' efforts to consolidate its many and varied services into a handful of categories produced the following:

	Inpatient	Outpatient	Residential; Crisis & Respite	Recovery Support Services	Education; Research & Prevention
Mental Health	Psychiatric Forensic Enhanced Security	PHP, IOP, Forensic community, ACT, Case Management, Care Coordination, BHH, Outreach & Engagement, Community Support	Group homes, Transitional, Sub-acute, Mobile Crisis, CIT, Respite, Intensive Residential	Housing/Housing Supports, Supportive Housing, Supervised apartments, Peer Services, Advocacy, Social & Vocational Rehab, Supported Employment & Transportation	Supported Education, Staff Training, Suicide & Violence Prevention
Substance Use	Medically managed & monitored detoxification	IOP, MAT, Ambulatory detoxification, Case Management & Community Support	Intensive, Inter-mediate & Long-term Residential & Halfway Houses	Recovery Houses, Peer Services, Advocacy	Staff Training, Tobacco Retailer Compliance, Violence Prevention , Substance Use Prevention

The biannual priority setting process created a grid to assist in the prioritization process within each region which utilized the 5 core functions identified by DMHAS found in the table above. Based on the various surveys and focus groups held across the state, each region established overarching issues, strengths, top 3 priorities, system gaps/barriers, and emerging issues as well as recommendations. The report which follows covers all these elements, although system gaps/barriers and recommendations are embedded within the topic areas rather than separated out. Again, as noted above, some concerns/recommendations are outside DMHAS' purview/mission or require funds which either may not currently be available or may not be permitted by regulations associated with the federal block grant. DMHAS applauds the efforts of the RMHBs and RACs in their priority setting process, but does not necessarily endorse every finding/recommendation which follows.

Overarching Issues

There was widespread concern about the state's budget and the as yet unknown total impact of cuts of services for persons with behavioral health issues. Even prior to the most recent budget reductions, capacity concerns across levels of care were expressed. Individuals with behavioral health issues sometimes end up in an inappropriate level of care due to a lack of availability at the appropriate level causing a cascade of capacity issues and a system without an adequate flow of clients to meet the demand. Repercussions of current and possibly future additional cuts are expected to make accessing

appropriate care even more challenging; lengthening already long waits, reducing already reduced services, and costing the state more in the long run due to more expensive emergency/crisis situations resulting from lack of timely medication management, psychiatric and substance use assessment, and access to the appropriate level of care when indicated. Access to limited treatments slots is further compounded by perennial basic needs challenges, especially housing and transportation. *DMHAS Activities on this issue: Over the years, during times of budget shortfalls, DMHAS' top priority has always been the maintenance of treatment services. Shortfalls are always applied to non-service related areas first.*

The lack of safe affordable housing contributes to homelessness which results in transient persons not receiving services and being at increased risk for adverse events of all kinds. These individuals are more likely to end up in Emergency Departments (EDs). Despite progress in reducing *chronic* homelessness, those who are more *recently* homeless appear unlikely to get services and providers accuse the Coordinated Access Network (CAN) of being an unfunded mandate that has shifted the homeless from shelters to EDs. Supportive housing can prevent homelessness, promote self-sufficiency, and reduce use of more expensive levels of care. Adequate rental subsidies and support services are needed to provide stability and prevent re-institutionalization. Likewise, sober housing, which can vary dramatically in quality, requires more oversight, licensing, training, and support. "Mixed" housing was viewed as problematic given the different needs of the populations in need, such as older compared to younger adults. *DMHAS Activities on this issue: The 8 CANs in Connecticut are a federal Department of Housing and Urban Development requirement which have resulted in approximately 400 new federal housing subsidies being awarded in 2015 and 2016. Targeting chronic homelessness - the most severe and costly form of homelessness - doesn't end all homelessness as it is a dynamic problem. The Partnership for Strong Communities, through the Reaching Home Campaign, has developed workgroups to address all types of homelessness, including chronic, short-term, Veterans, youth and family. Related to sober housing, Supported Recovery Housing Services (SRHS) are defined as non-clinical, clean, safe, drug and alcohol-free transitional living environment with on-site case management services available. DMHAS's agent, Advanced Behavioral Health, Inc. (ABH) credentials SRHS providers, and contracts with them, to provide housing and case management services to people in recovery. ABH currently contracts with 14 Supported Recovery Housing Service Providers with a total of 48 locations and 208 beds (male/female). Providers may have additional beds not contracted under BHRP, as self-pay beds.*

Lack of transportation is particularly problematic in the more rural areas of the state (Eastern and Northwestern) where there are fewer services to begin with, an argument for greater use of telemedicine or a mobile service that comes to the person. Problems related to Logisticare cite rude drivers and extensive waits which at times result in clients missing/late for appointments and being penalized by the provider. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Across inpatient, hospital and correctional settings there was concern not only that people are discharged prematurely without being sufficiently stabilized, but also that inadequate discharge planning and follow up are contributing to recidivism, re-institutionalization, and even suicide shortly after release. While medications may be managed while the person is in the inpatient setting, longer-term wraparound supports are needed for the client and their family to increase the odds of a sustained recovery. Family members of a person with behavioral health issues need support and assistance with keeping their family intact. More follow up is needed to make sure that persons discharged get connected to the next level of care. *DMHAS Activities on this issue*: *There are emerging initiatives between Department of Correction (DOC) and DMHAS outpatient substance abuse services to ensure*

better connections to care for persons pre-release from DOC. These efforts are an extension of such programs operating in Bridgeport and New Haven that will now be expanded to Hartford.

Opioid Epidemic

The structure of the priority setting process in 2016 was based on large service categories and did not lend itself to organizing around topics like the opioid epidemic; however, given the scale of the problem it is being separately addressed. Admissions rates for persons with a primary diagnosis of heroin continue to climb, as, unfortunately, do the number of opioid-involved overdoses across the state. Often the overdoses occur within a few weeks of release from hospitals, prisons, and other institutions due to a decrease in tolerance to the substance caused by a break in use. Some concern was expressed about an apparent emphasis on methadone in response to the opioid epidemic. Other treatment options are, of course, available at DMHAS programs, but medication assisted treatment (MAT) is an evidence-based practice proven to decrease illicit drug use, criminal activity, and infections. The suggestion to allow Advanced Practice Registered Nurses to be able to prescribe Suboxone and thereby further expand access to this medication has been accomplished by federal law via the Comprehensive Addiction Recovery Act (CARA 2016). Safe disposal of unused and expired medications has received much attention as about 75 police station lobbies across the state now have medication drop boxes, however, it's been suggested that more convenient drop box locations are needed outside of police stations for those who are uncomfortable with this location or have difficulty accessing it due to age or disability. The new DMHAS call line meant to assist those with opioid use disorders to access services was commented on during the priority setting process with the feedback that some callers had been told the number was only for persons using certain substances, not all substances, and only for those in need of detoxification. Those needing other services were advised to call 211. The 211 call number has also received comment, including that most people lack awareness of this service and that the 211 system needs more staffing and more training, including in customer service skills. *DMHAS Activities on this issue: This topic has resulted in positive cross agency and community stakeholder collaborations. Significant resources have been dedicated to raising awareness and educating the public via community forums and public service announcements. Expansion of (MAT) through methadone clinics and suboxone prescribing are underway and more is expected as DMHAS received a SAMHSA grant for this purpose. Training on Naloxone for opioid overdose reversals is ongoing with clinicians, administrators, police officers, school personnel, and other organizations and community members.*

Strengths

Responding to Current Conditions:

Much positive legislative activity has occurred related to current crises situations. Related to the opioid epidemic, reestablishing the Alcohol and Drug Policy Council (ADPC), establishing a 7-day limit on prescribing of opioids, raising the capacity for physicians with the DATA waiver to prescribe buprenorphine, medication drop boxes for safe disposing of prescription medications, more first responders armed with naloxone, RAC funding, and pending agreements to place recovery coaches/crisis workers in EDs are all underway.

Mental health clients in crisis have the benefit of staff expertise and services that continue to become more integrated. Local Mental Health Authorities (LMHAs), working with law enforcement, other emergency responders, and town personnel continue to coordinate to serve those in need. Both Crisis Intervention Training (CIT) for police and Mental Health First Aid (MHFA) training for community members continue to be offered and seem to be making a difference in terms of greater understanding and recognition of common behavioral health crises. In response to barriers in accessing timely mental health services, some programs now offer same day or next day access.

Integration Efforts:

Community Care Teams (CCTs) have been developed in many locales and are targeting frequent ED users/Inpatient admissions and assisting those clients with wraparound services which address the wellness of the whole person. It was suggested that the cost savings realized from the activities of the CCT should be sufficient to fund a navigator for each CCT. It was recommended that there be coordination amongst the existing CCTs to ensure consistency of services provided.

Behavioral Health Homes (BHHs) are serving those with complex medical needs by either establishing medical clinics onsite or establishing a close working relationship with a nearby hospital for medical services. Some providers have become certified Federally Qualified Health Centers (FQHCs).

Greater awareness and collaboration between behavioral health and law enforcement providers is benefitting both systems and has resulted in more training and greater familiarity of mental health and substance use initiatives.

Homelessness:

Coordinated Access Network (CAN) has made progress toward ending chronic homelessness and there are two supportive housing options in Manchester described as “stellar”.

Wellness:

The concept of treating the whole person known as “wellness” continues to gain momentum. To a certain extent, dissatisfaction with the existing system (including instances of doctors not listening to clients or minimizing their medical issues or focusing only on medication) has been the impetus to the rise of the wellness phenomenon in which clients are empowered and the focus is on meeting their own needs. This is consistent with recommendations to teach clients self-awareness and self-care and having them develop skills rather than having providers do it for them. The need for less focus on diagnosis and more on providing alternatives and actual help, as was noted from the respondents, captures this. Involving more people in the wellness movement as a prevention effort was recommended because of its increased client participation and cost-effectiveness. This would include mindfulness, art and self-expression activities. Others propose having actual tutoring in math and writing skills. The TOIVO program offers education, support groups and alternative approaches to healing and wellness. The In Shape program, which focuses on exercise and nutrition, uses positive reinforcement with participants and is successfully reducing stress and anxiety. Some clubhouses are offering activities and groups that people want to participate in, like smoking cessation, yoga, healthy eating, and spirituality, and in an environment where those participating also develop friendships. Another provider has incorporated skill building, wellness groups and activities that are also drawing people in that might not otherwise be interested.

Recovery Supports:

Connecticut has invested in training certified Recovery Support Specialists through Advocacy Unlimited (AU) and Recovery Coaches through Connecticut Community for Addiction Recovery (CCAR). Many are working in the system, providing support for socializing, recreation, self-advocacy, employment, and community living skills.

DMHAS and its providers are committed to recovery support services, including services provided by CCAR (Recovery Coaching training, telephone support, and volunteer opportunities). Clubhouses and social programs are helping people develop relationships and success in the community by assisting them with education and training, support, activities, and stress reduction.

Top 3 Priorities

#1- Outpatient Services:

Outpatient services were of greatest concern statewide due primarily to limited access/capacity. Some programs have closed due to budget reductions or financial losses associated with insufficient Medicaid reimbursement amounts. The other barriers identified were a shortage of psychiatrists/prescribers and, of those practicing, many not accepting public insurance, including Medicaid. This situation is characterized by extended waits for outpatient appointments and larger caseloads for outpatient personnel. In response to the situation, some outpatient providers, rather than close, have cut back on services and hours, including replacing individual with group sessions, focusing on medication management rather than client skill development, and eliminating the possibilities of any extended service hours or bilingual staff. On the other hand, some providers have opted to attempt a same day access model, which was applauded by respondents and considered worth attaching incentives to.

More provision of services by case managers, CSP and ACT providers and other support services were recommended not just to assist targeted clients in maintaining treatment gains, but to make available to the overall population. Likewise, Outreach & Engagement, which is also part of the "Outpatient" category, were recommended for those in transition between different levels of care (including release from prison to community), persons who drop out of treatment, those in crisis, persons without transportation, persons with substance use disorders, seniors with behavioral health issues, and homeless persons. A number of participants felt they weren't adequately informed of all the outpatient services that were available to them, including peer supports. There was also the mention of having navigators available to assist clients with identifying and accessing resources. *DMHAS Activities on this issue*: *DMHAS just completed a redesign of residential support services and converted many programs to Community Support Programs (CSPs) to provide better standardization of services. There are now 28 agencies and 39 distinct CSP programs available.*

For persons with substance use disorders, accessing suboxone providers for opioid replacement therapy (ORT) has been a challenge given federal limits on the number of persons a prescriber can have on their caseload. The Department of Health and Human Services (DHHS) has recently expanded this capacity which should make this care more accessible. It was also reported that Ambulatory Detox is an underutilized level of care that more people could access. *DMHAS Activities on this issue*: *DMHAS was awarded a grant for high risk communities to expand access to Buprenorphine. The communities of Torrington, Bristol/New Britain, and Willimantic/Windham will not only receive funds to support expansion of Buprenorphine treatment but will also be able to hire a recovery coach at each site to assist in the process.*

The nationwide shortage of psychiatrists will not be resolved quickly given they are an aging profession with many working only part time.

#2-Inpatient Services:

Extended waits to access inpatient beds were reported with many persons occupying general hospital beds/"boarding" in EDs for the interim. The hospitals believe they are seeing more clients coming to them with behavioral health concerns. It was reported that it is particularly challenging to access inpatient beds for clients with co-occurring conditions and that community inpatient programs are reluctant to accept these more complicated co-occurring clients, preferring to leave such clients to state-operated programs like Connecticut Valley Hospital (CVH). One recommendation in this regard is to shift designation of some inpatient beds to be strictly for co-occurring clients.

For clients with substance use disorders, it's reported that accessing an inpatient bed is difficult unless the person is referred through the court/criminal justice system. Complaints about persons needing to be "high" at the time of admission screening or that they need to "fail" at a lower level of

care to be admitted suggest that improper use of the American Society of Addiction Medicine (ASAM) admission criteria is occurring. Other unnecessary barriers include programs refusing persons prescribed psychotropics or certain arbitrary dosages of methadone. Complaints about insurance company barriers included dictating treatment options and caps on number of treatment episodes.

Mental health clients at CVH were reported to not be receiving sufficient therapeutic groups, adequate visitation opportunities or sufficient coordination with lower levels of care (LOCs) and housing options.

Across all inpatient settings there was concern that people are discharged prematurely – staying only long enough to have their medications managed, but not long enough to be stabilized and to acquire the skills needed to be successful at discharge. Better discharge planning/aftercare arrangements are needed including longer-term transitional wraparound supports for the whole family, in order to increase the chances for a sustained recovery. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

#3a- Workforce:

The first priority that was part of a 3-way tie for third most important is workforce. The state-operated system has been affected by layoffs which result in "bumping" per union contract. Impacts of this "bumping" include disruption for services and clients, including potential loss of a particular expertise/specialty.

At the private non-profits (PNPs), those providing direct services to clients are described as the "working poor", unless they are part of senior management. Not surprisingly, this leads to substantial turnover of direct care staff which, as for clients in the state-operated system, is disruptive. The perspective of the PNPs is that their funding should be increased.

Impacts for the DMHAS-operated and –funded system include increased workload, stress, and difficulty being released for training. Having to "do more with less" is the mantra.

There is a state as well as a nationwide shortage of psychiatrist/prescribers, along with, in some regions, bilingual staff, social workers, and case managers. Training of the existing workforce was also recommended, including educating providers about trauma-informed care, evidence-based practices (EBPs), cultural competence, and safe opioid prescribing practices. *DMHAS Activities on this issue*: *A review of training opportunities for DMHAS staff from the Winter Catalog 2017 and Web-based Trainings: Trauma-informed practice in Behavioral Health Care; Best Practices in Anger Management; Best Practices in the Treatment of Depression and SUD; Addressing behavioral health needs of veterans; Gender-responsive substance abuse treatment for women; Cultural competence primer for behavioral health practitioners and settings; Cultural Elements in treating Hispanic and Latino populations; Understanding Trauma related to Trauma-informed care; and a variety of trainings related to opioids and addiction. Additional training resources are available, but not listed here.*

Issues related to peers also fit in this section. Recovery Coaches serve as mentors/guides for individuals with substance use disorders. The Coach empowers the individual in their personal journey toward recovery by offering hope while providing advocacy, guidance, support and knowledge. Because these positions aren't reimbursable, they're underutilized and not enough positions are available. Use of peers to bridge service gaps is recommended as a cost-effective solution, especially to assist with compliance and follow through for persons being discharged from EDs or otherwise transitioning. Persons experiencing some sort of crisis, including overdose, are at a critical point at which engagement may be most advantageous. The Yale Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence program was put forward as an example of an innovative model to be replicated. Some misunderstandings have developed in terms of the role of the peer, in which some

peers conceptualize of themselves as advocates, not actual service providers. There is a waiting list for Recovery University. Creation of more groups with persons in recovery like the Consumer Action Panel in Torrington was suggested. *DMHAS Activities on this issue: DMHAS has an initiative in process to expand the peer workforce into hospital emergency departments*. *Trained recovery coaches will reach out to ED patients and their families to provide assistance when a desire for recovery is indicated. Manchester, Windham, Norwich and New London Hospitals will have Recovery Coaches connect with patients who have overdosed or with alcohol/substance-related ED visits. The goal is for a rapid response by the recovery coaches (≤ 2 hours) to engage the patient and connect them to a provider/recovery supports and with transportation as needed, including resource materials that can be taken with the patient/family at discharge. A second DMHAS initiative is a project covering calendar year 2017 designed to assist agencies with integrating Recovery Support Specialists. This initiative is designed to assist up to ten (10) agencies in supporting and maximizing the contributions peer staff can make to promote the recovery of persons with serious mental illnesses and co-occurring substance use disorders. The training and technical assistance will be provided at no cost to the selected agencies and is funded by DMHAS through the Yale Program for Recovery and Community Health (PRCH) and Advocacy Unlimited.*

#3b-Education/Research/Prevention:

The second priority that was part of the 3-way tie for third most important is Education/Research/Prevention which many expressed were critical across all levels of care. Each element will be addressed separately.

Education of town services staff was suggested along with more required funding and training for Crisis Intervention Training (CIT) for police officers. Additionally, providing accurate information about the negative effects of marijuana was recommended, particularly for young adults. Raising awareness of common mental health conditions and wellness were recommended. *DMHAS Activities on this issue*: *There were 194 MHFA training sessions and 91 YMHFA training sessions in FY 15. For FY 16, there were 152 MHFA training sessions and 74 YMHFA training sessions. As a result of ongoing CIT training sessions, there are now 95 police departments with at least one trained officer and 1754 individual officers trained.*

Research recommendations included collecting data on wait lists, assessing the impact/cost-savings of providing mental health supports, monitoring the impact of budget cuts, and legislative review of standards for merchant education on tobacco, alcohol, medical marijuana and gambling.

Prevention recommendations primarily focused on substance use and suicide with few exceptions. More prevention efforts in K-12 public schools targeting primary substance use prevention and other behavioral health issues was expressed with the concern that social media is playing a role in children trying out substances earlier. Directing prevention efforts toward those at greatest risk of overdose, making naloxone more accessible to reverse opioid overdoses, and placing medication drop boxes in places where people will be more comfortable using them rather than in police station lobbies were all suggested. Related to suicide prevention, more was recommended, including the Zero Suicide Initiative, along with integrating these efforts to deliver local level support. *DMHAS Activities on this issue: The Governor's Prevention Partnership provided 810 services reaching over 19,000 individuals targeting schools, colleges, workplaces, media and communities. Through the Garrett Lee Smith (GLS) Suicide Prevention Initiative, comprehensive evidence-based suicide prevention/early intervention efforts on college campuses across the state served students with screening and professionals with training. Information on mental health and substance use issues was disseminated through a variety of media outlets to thousands of residents via the Connecticut Center for Prevention, Wellness, and Recovery. The*

most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.

There were a few comments related to stigma, including a point of view that the term "behavioral health," which has been adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as many other organizations, is "misleading and increases stigma." Changing society's attitudes is still needed for those with mental health and substance use disorders and their families. *DMHAS Activities on this issue*: *DMHAS has several new public service announcements specific to the opioid epidemic and its consequences on individuals, families, and the community and these have been presented to the Alcohol and Drug Policy Council and are available on the DMHAS website.*

It was suggested that the Strategic Prevention Framework (SPF) which has been in place for years be replaced with a new prevention model and that prevention efforts reach across the life span. Changes were also recommended to the secondary prevention plan to include the programs: SOS, A-SBIRT, QPR and MHFA, some of which are already being offered. Another recommendation was to fund the Connecticut Prevention Network (CPN) to conduct twice annual prevention forums to improve delivery of EBPs.

#3c- Residential/Crisis/Respite:

The third of the 3-way tie for third most important priority is Residential/Crisis/Respite care which covers a wide swath of services. While each element will be addressed separately, some common themes were expressed which applied across the entire range. A lack of capacity across this category was identified and it was pointed out that two transitional residential programs had closed. Stigma was described as a barrier to new housing as everyone is familiar with the NIMBY (Not in My Backyard) phenomenon. A lack of transitional support from 24/7 to step down levels of care was also expressed. Inadequate reimbursement rates for residential treatment and poor pay for residential staff make it difficult to maintain staff and services. For some clients, especially complicated co-occurring clients, the maximum length of stay may still not be enough to result in a successful discharge. Finally, inmates being released from prison with behavioral health needs are challenged to find housing.

Residential services for those with substance use disorders were described as having insufficient capacity to meet the demands. During the waiting period for admission to certain programs, people are expected to call daily to retain their spot on the waiting list, often while they are on the street and at risk of relapse. There are no sobering centers at which to safely wait for residential treatment and no "wet houses" to safely sober up for those not ready for a higher level of care. Some programs won't admit potential clients unless they already have a place to discharge to afterwards which is problematic for clients that are homeless. As mentioned previously, there are also insurance barriers reported such as needing to fail lower levels of care first, needing to be intoxicated at the point of admission, or arbitrary caps on number of episodes of treatment that will be covered. Again, these barriers suggest incorrect interpretation of the ASAM criteria. It was suggested that more services be directed toward direct client contact early in the recovery process.

Residential housing for those with mental health conditions (group homes or supervised apartments) was described as having insufficient capacity to meet the demands. The Greater Danbury area has no group homes. Residential options for interim and higher levels of care are recommended. Clients become comfortable with their current level of care and stepping them down to a lower level of care becomes a challenge that they resist. They may not have the financial resources to move their belongings. They may have difficulty in relating to others in the household or other issues like hoarding which serve as a barrier to housing options. It was suggested that those persons who hoard should have this condition addressed by both health providers and municipal services. The transition from group home to independence is dramatic and needs an interim level if the person is to succeed. Medicaid

Rehab Option (MRO) group homes have requirements including 40 billable hours of services/month which can be a challenge to meet. Also, group homes with more flexibility than the MRO requires were recommended. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations addressing the need for higher intensity mental health residential treatment beds for the more disabled clients challenged by program demands and in need of more extensive assistance than other clients.*

Crisis services are understaffed and lack capacity which translates into reduced hours of service, extensive waits for service, and reliance on a law enforcement response. Strict fidelity/model requirements of mobile crisis limit flexibility and serve as a barrier for some. It was recommended that the evaluation of crisis services be modified to target understanding what the client's experiences were. It was suggested that 23-hour crisis beds be created.

Respite care was described as lacking capacity and as being misused long-term by persons who had no other placement option. Similarly, it was suggested that increasing respite bed capacity might alleviate other capacity issues in the system. *DMHAS Activities on this issue*: *DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

Other Priorities

Recovery Support Services:

Recovery Support Services did not rank in the top three priorities, but received a number of comments and recommendations. Related to housing, concerns were expressed about trying to access a shelter bed through 211 and CAN, needing a certain income for eligibility for public housing, long waits for Section 8 vouchers and the challenge of housing persons released from prison. Specifically for persons in recovery from substance use disorders, having halfway houses and *supervised* sober houses was emphasized along with a request to maintain people in recovery support services even if noncompliant. Also related to recovery from substance use disorders, it was suggested that alternative to traditional 12-step self-help groups be made available and that services be available 24/7. Concern was expressed over inaccurate online information about mental health services and that clients with such issues weren't always informed about available services, including clubhouses and vocational services.

There were a number of comments and recommendations related to supported employment. Despite efforts to educate clients to the contrary, many still believe that they will lose their benefits if they become employed. Challenges to employment include the overall high unemployment rate, clients with a substance use or criminal justice history, and lack of access to Employment Specialists. Referrals to the Supported Employment program are low, which respondents attributed to Waterbury Hospital not participating in the referral process. This underutilization could be an opportunity for those wishing to participate in supported employment programming. Staff that operate in the Supported Employment program are challenged by having to develop job opportunities for clients at the same time that they have to support their clients in their recovery process. A suggestion was made to assist clients' efforts at starting their own businesses. The IPS model was described as limiting flexibility and budget cuts to DOC apparently eliminated an option to IPS. *DMHAS Activities on this issue: This concern about lack of flexibility with IPS has been addressed as programs wishing to use an alternate model simply need to put their proposal for an alternate plan in writing for review by the program manager*. *The Supported Employment Grant that DMHAS was awarded is currently working with two priority populations: the Latino population in Hartford and individuals with criminal justice involvement in New Haven.*

Transportation issues were again a significant concern in the priority setting process. Complaints about Logisticare, especially the rudeness and lack of promptness of the drivers, continue and a barrier to being able to lodge complaints against them was described. Recommendations related to

transportation included: having mental health and substance use transportation resources shared, enforcing the med cab contract with an emphasis on respectfulness being a must, having the med cab operate in isolated parts of the state, working with towns for use of available town vehicles, replicating the Reliance House model of "punch cards" for rides, supporting a limousine service, funding a mobility coordinating position, and investigating other transportation possibilities. *DMHAS Activities on this issue*: *Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Special Populations of concern:

As in previous reports, the majority of concerns expressed for special populations were age-related.

Young Adults (YA) – tailoring services for the unique needs of young adults was emphasized. Providing younger adults with services designed for older adults (example provided was traditional AA meetings) is not a good match and fails to engage them. It was recommended that services provided by CCAR be tailored for adolescents.

Special concern was expressed for young adults in college with behavioral health symptoms. Symptoms significant enough to interfere with the student's ability to succeed in this environment are reportedly common, but infrequently reported. College personnel, in turn, are unaware of which students are in trouble and the behavioral health services that are available on campus are often limited. Further complications regard parental notification and consent. For college students with substance use problems, sober campus housing and activities were recommended. This recommendation aligns with suggestions for a Recovery High School for students still in public school who have substance use disorders. Additionally, developing Alternative Peer Groups (APGs) to support young persons in their recovery from substances were recommended. The APG model is a program involving peers to provide positive peer pressure and support.

Persons aging out of DCF appear to have the advantage in accessing young adult services (YAS) which means those without a DCF referral are at a disadvantage. A lack of capacity for YAs at CVH was specified. Not being informed of other available services, including peer supports and treatment outside of DMHAS, was a concern. For those actually receiving services, some reported disrespectful/unhelpful staff, the need for assistance with furthering their education/employment, and clients aging out of YAS without being fully prepared for discharge. *DMHAS Activities on this issue*: *DMHAS YAS program is designed for clients 18 – 25 with a history of DCF involvement and major mental health problems. In SFY 2016, YAS programs served 1,225 clients, an increase of 3.5% over the number served in the previous fiscal year. Almost 50% of clients were able to live independently after discharge from YAS, more than a third had earned a GED/high school diploma, more than a quarter were employed, and over 59% were living stably in the community.*

Older Adults - a service gap identified was older adults with complex medical needs with or without substance use problems who are either house-bound and need services brought in or without residential placement options. In addition, there are older adults with mental health issues who lose family support as they age and are sometimes put in the demanding role of caregivers to other family members. *DMHAS Activities on this issue: The asset mapping project has been completed by the Older Adult Workgroup and subcommittees are actively working on the top priorities which are: 1) Developing and embedding training on older adult mental health issues into other training as part of a professional development effort; 2) identifying existing databases on older adults; 3) creating a process of "no wrong door" for older adults in need of services. Additionally, they are collaborating with DMHAS Workforce Development to create an online training on older adult behavioral health issues for the Learning Management System.*

Co-Occurring Clients –For person struggling with co-occurring conditions, integrated mental health and substance use services should be an expectation, not an exception. It was reported that some mental health services don't want to treat clients on methadone maintenance. *DMHAS Activities on this issue*: *All DMHAS LMHAs are involved in a learning collaborative to offer Buprenorphine as part of MAT. LMHAs have also been participating in naloxone training. Additionally, monitoring conducted by the DMHAS Community Services Division (CSD) of substance use programs examines the extent to which mental health services are provided and at this point, many substance use programs now provide mental health services to the clients they serve.*

Criminal Justice Involved Clients – Many persons who are incarcerated struggle with mental health and/or substance use disorders. Treatment, rather than incarceration, should be indicated. Jail diversion was recommended for expansion along with providing education to judges about the option.

Other populations – Persons in these other special subpopulation groups were only mentioned in terms of needing access to services: hearing impaired persons, hoarders, undocumented persons, persons whose primarily language is other than English, minority LGBTQ youth and young adults, and transgender persons who were described as not supported in the region. *DMHAS Activities on this issue*: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Insurance issues:

Barriers due to insurance practices were illuminated including: spend down requirements, short re-determination periods, Husky C not covering substance use services/residential treatment (a check of this reveals that while Husky C does not cover residential, it does cover inpatient and outpatient services), high co-pays and deductibles, and insurances that aren't accepted by providers (ex. Medicaid).There was a complaint about a young adult being "forced" into Husky insurance even though the person was covered by private insurance.

Integrated/Coordinated/Technology Informed Care:

There was a general call for developing coordination mechanisms to bring providers together on a regular basis to coordinate care for clients that they share. The care provided should be "wraparound" including areas such as housing and medical services.

CCTs and BHH are positive examples of how this can work, but at least for the BHHs, some problems were identified, including that dual eligible clients (Medicare and Medicaid) may not be eligible for BHH, high caseloads, lack of communication across primary and behavioral health providers, "spillover" to CSP or waiting lists, and physicians ignoring medical complaints of mental health clients. A call for integration of medical services at other levels of care outside BHHs was indicated.

Using current technology, including social media to improve centralized registry, help clients find therapists or social/recreational opportunities for clients and those who support them and recommended resources can all be possible with technology.

Emerging Issues

Cuts associated with the budget deficit are foremost on everyone's minds in terms of what the impact will be for services in the state. This concern has overshadowed other issues and was described earlier in this report.

The most frequently identified emerging issue was the Opioid crisis, despite the fact that the epidemic was identified in 2012 and has seen a significant response from the state since that time. The magnitude of the impact of such widespread opioid use, including overdoses, has attracted a lot of attention and consequently this topic was addressed earlier in this report.

Marijuana is an emerging concern as more states around the country are legalizing the drug for medical and recreational use, including neighboring states. Data is just becoming available from states such as Colorado that legalized marijuana a few years ago and can serve to inform Connecticut about likely consequences to be faced. Respondents continue to ask for accurate information on the negative consequences of marijuana use. <u>*DMHAS Activities on this issue*</u>: *A few of the providers in the Connecticut Strategic Prevention Framework Coalitions (CSC) initiative are targeting marijuana in their prevention efforts based on community needs assessments. They include: the Town of Clinton, Rushford (Middletown), Child & Family Agency of Southeastern CT, Inc. (Lyme/Old Lyme), and Ledge Light Health District (Groton). The CT Clearinghouse continues to serve as a resource for education on marijuana and distribution of related materials. Additionally, many prevention evidence-based practices address substances as a whole which may include marijuana.*

Problem gambling was identified as an emerging issue in light of Keno and new casinos being built which will increase accessibility to gambling.

Greater awareness of transgender persons, the stigma they face, and lack of support that appears to be available for them is an issue that has moved to the forefront. <u>*DMHAS Activities on this issue*</u>: *With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled* ***Gender Dysphoria: A Behavioral Health Perspective on Transgender People*** *available to all DMHAS employees; 2) A 25 minute video entitled* ***Becoming Myself: A Transgender perspective on Behavioral Health*** *has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Suicide rates have risen and there is concern that at least some of the overdoses reported as accidental-drug-related-deaths might, in fact, be intentional rather than accidental. <u>*DMHAS Activities on this issue*</u>: *DMHAS has been very active and supportive of various suicide prevention programs (e.g., QPR; one word, one voice, one life) which are ongoing across the state. The most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.*

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, January 18, 2017 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 365	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Mui Mui Hin-McCormick Ingrid Gillespie, Margaret Watt, Kati Mapa, Nan Arnstein, Ellen Econs	
Staff Present:	Jim Siemianowski, Chrishaun Jackson	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes approved without correction.	
Block Grant Update Jim Siemianowski	The full block grant is due September 1, 2017. The MOE issue has not been resolved which may be related to the change in administration. We resubmitted data and are awaiting a reply. December 1st DMHAS was required to have submitted annual reports for Substance Abuse and Mental Health block grants. We anticipate any revision requests to be completed in a timely manner. CMHS assigned a new MH project officer, Frank Cruzata and Lisa Creatura has replaced Mary McCann as the SA project officer. We were in communication with the First Episode Psychosis (FEP) programs in response to the increase in set-aside funds from 5 to 10%. DCF originally focused funds on trauma training in the schools, but the increase in funds came with more specific requirements that the funds be focused on FEP. As part of the shift, DCF wanted to use Beacon for care management, case finding and engagement of individuals who are on Medicaid and may have early onset psychosis. Issues to resolve related to involving Beacon in helping to identify young people with FEP include: • Clarifying criteria which might identify a person with FEP who don't yet have a diagnosis • Determining how to engage and transition persons that have been identified and are interested in additional services	

	DMHAS will schedule a meeting with Beacon and the two FEP programs will be scheduled.	
DMHAS Update Jim Siemianowski	• DMHAS submitted their budget options before the holidays which did not include lay-offs or grant cuts beyond what was already taken. There is some concern because we submitted 5% and the Governor asked agencies to submit 10%. They could come back and choose to say give 5% more in staff. • The federal government has awarded money to states for the Opioid epidemic. Planning and recommendations have surfaced through the ADPC. Forums were held through the CORE initiative that the Governor asked Yale to focus on. One grant is due Feb 17th. If awarded, Connecticut will receive 5½ million/year for 2 years. The grant is very prescriptive stating that 80% has to go to treatment, 5% for administrative costs, and the remainder for prevention to focus on increasing access to medication assisted treatment.	
Block Grant Priorities Marcia DuFore	Handout given SAMHSA does not want federal funds spent on reimbursable levels of care (which could possibly change with the new administration). While the priorities of this group have focused heavily on outpatient' DMHAS does not fund outpatient very heavily anymore. • Outpatient handout reviewed The data shows that we have outpatient programs all over the state but the issue people have identified is insufficient capacity, psychiatrist time, and prescriber time. The population DMHAS serves are likely on Medicaid. Some issues that have been identified are also related to reimbursement. Without adequate reimbursement, they will lose money on these clinics which is one of the difficulties in trying to deal with this equation. As suggested, we are looking at outpatient recommendations from our priority setting process and DMHAS data; gather concerns/ identifiers and create a structure to ensure that it gets addressed in the block grant:	

	• Getting outpatient appointments • Getting a live person on the phone • Missing appointments • Residential programs are only 90 days as opposed to 6 months (SA programs) • Non DMHAS services-people are going elsewhere • The collection of data requested when trying to get help • Intake concerns • Support • In-home care • licensing issues/ clinicians do intakes Next steps: 1. helpful to conduct a questionnaire (similar to Margaret's) 2. phone call to clinical directors/providers	
Other Business Marcia DuFore		
Meeting Adjourned		
Next Adult meeting:	April 19, 2017 from 12:30 PM – 2:30 PM, Room 365, Page Hall, CVH	
Respectfully submitted:	Susan Wolfe, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, April19, 2017 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 365	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Ingrid Gillespie, Margaret Watt, Kati Mapa, Tom Steen, Magda Lekarczyk, Peggy Ayer, Ingrid Gillespie, Kristie Barber and Irene Herden	
Staff Present:	Jim Siemianowski, Chrishaun Jackson, Susan Wolfe	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes from the January meeting were approved with one correction.	Minutes will be corrected.
Block Grant Update Susan Wolfe	• No word yet in response to our SAPT MOE waiver request. NASADAD is conducting phone interviews with selected states concerning MOE and we are waiting for this to be scheduled. • A CSAT visit with our new project officer, Courtney West, is scheduled for May 2-4. During the visit she will be meeting with DMHAS managers overseeing various programs and will conduct 3 site visits: 2 at women and children's programs and one at a CCAR recovery center. • Interim Update Format – Biannually, in even years, the priority setting process is conducted by the RMHBs and RACs and regional reports are prepared. In odd years, updates to those reports are submitted. The format for the update in 2015 was distributed and reviewed. There was consensus that the 2015 format was satisfactory, although the impact of both budget cuts and approved grants should be figured into the update. The forms will be emailed by Susan out to the RMHB and RAC directors and are due to be returned on Friday, July 28, 2017.	Susan will email out the updated Interim Update Formats to RMHB and RAC directors.
DMHAS Update Jim Siemianowski	• DMHAS submitted the Annual Report on December 1st. We were informed that there would be an MOE issue this year. We are still waiting on the MOE request that was sent 1 year ago. MOE is still out; no response as yet. We were alerted that there would not be a quick resolution due to the changes that are being made in DC with leadership. MOE was sent with notice that data from DSS is forthcoming. • Opioid grant for 5 million for 2 years was submitted, focusing on treatment and prevention. States will be allocated money based on a formula developed according to overdose statistics.	

	• In process of applying for another federal grant, Promoting Integration of Primary and Behavioral Health Care (PIPBHC). This **grant is for** 2 million per year for 5 years. Designed to continue integration of BH in Primary care. DMHAS put out an RFQ to try to identify people who are interested. ***Note: DMHAS had similar grant. RFQ specified that it did not want people who participated in "round 1" to participate again** • DMHAS continues to do work related to the budget. Specifically; Danbury and Waterbury closing; RFPs and CONs are in process.	
Regional Priorities & Recommendations/ Priorities for the BG/ Top 3 priorities from Survey Marcia DuFore Janine Sullivan-Wiley Margaret Watt Kristie Barber Kati Mapa Ingrid Gillespie Tom Steen Susan Wolfe	Each presenter took a topic area and presented highlights of the findings and recommendations from the Priority Setting Process. • Special Populations – young adults, older adults, criminal justice involved • Outpatient Services • Workforce Issues – Psychiatrists, other staff, peers, CSP, and Training issues • Recovery Supports – employment, transportation, housing/sober housing, integrated care & wellness, and the opioid crisis • Inpatient Services • Residential Services – crisis & respite, mental health services, and substance use services There was not enough time to get through every section during the meeting so there will be follow up via email. Susan had created a one-page handout that summarized the findings of all the regional reports and linked possible priorities related to the findings to the 18/19 block grant to be submitted. Additionally, the handout listed the top 3 priorities selected by the survey. Susan will email this info to the council members and solicit feedback.	Susan will email the council members possible priorities linked to the findings of the priority setting process for feedback and for other possible priorities.
Other Business Marcia DuFore	No other business was conducted.	
Meeting Adjourned		
Next Adult meeting:	July 19, 2017 from 12:30 PM – 2:30 PM, Room 217, Page Hall, CVH	
Respectfully submitted:	Susan Wolfe, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, July 19, 2017 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Ingrid Gillespie, Kati Mapa, Tom Steen, Magda Lekarczyk, Peggy Ayer, Ingrid Gillespie, Kristie Barber, Lisa Jameson, Ellen Econs, Nikki Richer, Mui Mui Hin McCormick and Irene Herden	
Staff Present:	Karin Haberlin, Chrishaun Jackson, Susan Wolfe	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes from the April meeting were tabled as one section was blank.	Minutes will be corrected and brought to the next meeting for approval.
Block Grant Update Susan Wolfe	• The 18/19 Block Grant Application is due September 1st, 2017, but we have to work back from that date to fit in posting it to the web for public comment, review by this body (Planning Council), and obtaining the Governor's signature on the assurances and certifications. • The mental health and the substance use Allocation Plans were due on Monday, July 17, 2017, but they are still being worked on. OPM directed us to use the President's proposed budget to complete the plans and this means a 0.2% reduction for SAPT and a 26.5% reduction for MHBG. • The DMHAS and DCF state planners met with the chairs of the Adult and the Children's Planning Council last week to further discuss the priorities for the 18/19 Block Grant Application. Some items are proposed to serve as both priorities and as presentations to the planning council. Proposed as presentation topics for the Adult Council: o New CSP programs/fidelity reviews/outcome measures o One Key Question to determine women's reproductive intentions o Results of outpatient wait time study by Regional Mental Health Board Directors • And presentations proposed for the Joint Council: o Transportation/Mobility Managers o Expansion of MAT/Learning Collaborative o Expansion of Recovery Coach Services/Manchester HOPE initiative	

	○ Zero Suicide model (scheduled for the September meeting) ○ STEP program/Beacon contract (ESMI) (scheduled for November meeting)	
18/19 Block Grant Application Presentation Susan Wolfe	A handout outlining the different sections of the block grant and changes from the 16/17 block grant application was distributed. The State Information section was reviewed and changes described. The Planning Steps section was presented and the ways in which DMHAS fulfills the requirements for assessing the service system strengths and needs (with the behavioral health needs assessment based on a variety of data sources); identifying unmet needs and critical gaps (the priority setting process and results); and the Quality and Data Collection Readiness (describing the DMHAS and DCF data collection systems). The Planning Tables generated much discussion. The DCF-generated priorities related to Childhood Trauma, Family Engagement, Workforce Development, and Prevention of Suicide/MI were unchanged from the previous block grant submission except that the numbers were updated. • It was noted that for the PWID (previously IVDU) priority to increase the number of LMHAs prescribing Buprenorphine, DMHAS had reached out to DCF to see if they had an indicator they would like to add since they are making similar efforts within their department to address the opioid crisis. • There was clarification about the priority related to enhancing transportation that indeed this was related to the DMHAS 1-800 number designed to provide treatment on demand for persons with opioid use disorder and that rides, while primarily delivering clients to detox, could transport clients to other locations. It was recommended that an indicator for this priority be the percent of people who call to get rides and are actually accepted into treatment. • Expanding Recovery Support Services by increasing the number of Hospitals with Recovery Coaches caused much discussion related to the "siloing" of mental health and substance use rather than the integration. The Peer Specialists/Peer Bridgers as compared to the Recovery Coaches, receive different training, work in different locations, and support only mental health or substance use concerns rather than both. This is a much larger system issue and the Council made and approved a motion to draft a letter to the Commissioner regarding merging of peer services. • For the required SMI priority, the plan is to examine the 23 new CSP programs supporting SMI clients in the community in two ways: fidelity reviews and outcome measures. Council members agreed that the 2 indicators was a good idea.	If DCF provides a second indicator for the PWID priority, it will be incorporated. Susan will check with Lauren Siembab/Michael Michaud to determine whether this data is available. Marcia will draft a letter to Commissioner to be reviewed by the Council.

	• The TB priority, which plans to educate staff in infection control on the new risk factors/guidelines related to TB, was accepted without question. • New with this block grant is a priority for ESMI (Early Serious Mental Illness) which is the new term replacing FEP (First Episode Psychosis). Since the Beacon/DCF contract is the new piece, the priority indicator will be the percent of young people identified as ESMI who agree to engage in treatment. • The primary prevention priority options were presented in a handout based on data from UConn showing the problem substances in order: Alcohol (1st), Marijuana (2nd) and Opioids (3rd). Susan had endorsed marijuana as the priority based on the fact that the previous two priority setting rounds had identified the need for education on the risks of marijuana. It was pointed out that the way the priority was written confused perception of risk with use and needed to be corrected. It was agreed that changing the indicator from use to perception of risk was a better choice because it was felt there would be more of an impact, especially if the state chose to legalize recreational marijuana use. Further discussion resulted in a decision to have two indicators: adolescent and adult perception of marijuana risk, based on the idea that parents' influence children's likelihood of marijuana use based on their own beliefs that marijuana was the same as they had used as adolescents and was relatively safe. It was reported that there was much survey data to be able to measure these two indicators. One member felt that the primary prevention priority should be on cigarette smoking, but Susan pointed out that the data revealed that the top 3 concerns in Connecticut did not include cigarette use and that, in fact, cigarette smoking has been on the decline nationally for years. • The final priority is the one required for PWWDC on implementing One Key Questions in DMHAS women's programs. This priority was described as "an invasion of privacy" by one council member and not related to the reason women enter DMHAS treatment. After further discussion however, it was resolved that One Key Question serves to screen women to ensure their reproductive needs are being met by providing an opportunity to discuss reproductive preferences and related options. • When asked whether there were other priorities that should be added to the list, there was a discussion about the challenges of engaging clients in treatment. It was suggested that there was much work to be done in engaging clients in order for treatment to be effective and that it was difficult to measure engagement. In fact it can be measured by determining how many clients	Susan will change the indicators and correct any confusion in the language. Further discussions on the topic of

	have only a first, and no second appointments. But the bigger issue is whether strategies are being applied or planned to be applied to actually improve the level of engagement. There is no point in having a priority if it is not attached to initiatives designed to effect improvement. While this topic may not be appropriate for inclusion as a priority in the block grant, it is still worthy of further discussion. • Finally, the topics of mobile crisis and warm lines were brought up as needing attention. A particular case in region 5 was presented as an example of how mobile crisis can work effectively for clients and those concerned about them. But it was also pointed out that the resources are stretched and that there are inconsistencies across mobile crisis units with different hours, for example. It was suggested that there should be consistency across these programs. The first step seems to be looking at what each unit currently offers. The Planned Expenditure tables for mental health, substance use and prevention have yet to be completed. Fiscal/Prevention will complete them once the Allocation Plans are submitted. The Environmental Factors/Plan section which contains what are commonly referred to as "narratives" has switched for the most part from open ended questions to check boxes which are good in that they are simpler, but bad in that there is no opportunity to explain an answer. Support of State Partners was described as those other state agencies which DMHAS/DCF work with which provide support letters that are electronically submitted as part of the block grant application. The Planning Council section includes the members and their contact information; who they represent in terms of persons in recovery, family, providers, advocates or state employees, as well as diversity; ratio of those involved for personal versus professional reasons; and their input on the block grant, which is the purpose of this meeting. Finally, the block grant application will be posted to the DMHAS and DCF websites for a period of public comment which will also be incorporated into the block grant application. Marcia commented that greater effort to involve the planning council in the development of priorities was obvious. Others stated that the opportunity to have the discussion was a good opportunity. A couple of members expressed that the preponderance of priorities seemed weighted toward substance use, although another member pointed out that historically priorities had always been weighted toward mental health.	engagement should be scheduled. Members to collect data on what the different mobile crisis units offer. Planning council feedback and recommendations as well as those of the general public will be included in the block grant application.
DMHAS Update	• Privatization – was put on hold until after the union vote was finalized. The concession package for state employees was just approved, so privatization will not go forward per the agreement	

Karin Haberlin	worked out between the Governor and the unions. This means privatization efforts that were in the budget including closing Torrington and Danbury are not expected to be moving forward. DMHAS "paused" the RFP process for Torrington and has not moved forward with releasing the RFP for Danbury. It is not known what may happen if the legislature does not accept the union concession package. • Budget – DMHAS is evaluating how to manage the cuts that are being passed along to DMHAS under the Governor's Executive Authority. DMHAS' grant accounts have been reduced. Given the uncertainty of the budget, DMHAS is releasing only one month's funding to providers. All of these one-month payments should have been processed by the time of the Adult Council meeting. The council continues to experience a lot of anxiety due to the uncertainly of the times. • Grants – DMHAS continues to try to maximize funding by applying for federal grants. DMHAS has applied for SAMHSA's **Promoting Integration of Primary and Behavioral Health Care Integration Grant (PIPBHC)**. The grant would provide **2 million per year for 5 years**. This grant is aimed at better integrating primary health care with behavioral health care and would build upon integration efforts that began with our Behavioral Health Home Initiative. The grant would focus on Hartford, Bridgeport, and Waterbury. DMHAS has also recently submitted an application for a SAMHSA grant for **Pregnant and Postpartum Women**. This grant would be for **1.1 million per year for 3 years**. The grant is intended to expand the use of family based recovery and health services for substance using women. The goal is to enhance treatment options for these women and their families in the New Britain/Bristol and the Hartford/East Hartford areas. These areas were selected because these communities have a high number of risk factors related to pregnancy. These may include the following: inadequate or no pre-natal care, high teen birth rates, and high number of individuals below the poverty level. • Expansion of transportation for substance abuse services – DMHAS has expanded transportation to substance abuse services across the state as part of its 1-800 number. Transportation will be available between substance use levels of care including residential, DMHAS-funded recovery houses, and Supported Recovery Housing Services. Transportation must be accessed through the Access Line, 1-800-563-4086. While the rides are primarily to detox, other transportation destinations are possible.	
Other Business Marcia DuFore	No other business was conducted.	
Meeting Adjourned		
Next Adult meeting:	October 18, 2017 from 12:30 PM – 2:30 PM, Room 212, Page Hall, CVH	
Respectfully submitted:	Susan Wolfe, Ph.D.	

Adult State Behavioral Health Planning Council
Meeting Minutes

Meeting Day/Date:	Wednesday, October 19, 2016 - 12:30 PM – 2:30 PM	
Location:	CVH, Page Hall, Room 212	
Attendance:		
Members Present:	Marcia DuFore, Margaret Watt, Janine Sullivan-Wiley, Lisa Jameson, Kristie Barber, Kati Mapa, Mui Mui Hin-McCormick	
Staff Present:	Karin Haberlin, Susan Wolfe, Chrishaun Jackson	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**		Minutes were accepted without changes.
Priority Setting Process & Block Grant Requirements Susan Wolfe	In an effort to enhance the role of the planning council with input into the priorities selected for the biannual Block Grant Application, Susan created a handout and explained what the requirements were for selected priorities. The required populations were reviewed. The importance of selecting achievable and measurable priorities was emphasized. The schedule for providing a status report to SAMHSA via the Annual Reports was explained. Since the next set of priorities will be selected for the Application due September 2017, there is time for the Planning Council to be more involved in the process. Top regional priorities should be fresh in everyone's minds as the biannual regional priority setting process was just completed. Lisa suggested we make Human Trafficking a block grant priority. Other council members agreed that Human Trafficking is an important issue in the state, but pointed out that DMHAS is not the agency with primary responsibility to address the issue. However, the Council wants to be informed about the status of the situation. Mui Mui volunteered to get a status report for the November Joint Council meeting. After discussion, Marcia proposed that the Council attempt to bring together all relevant data on the topic of Outpatient treatment, which was identified as a prime concern across all 5 regions, for discussion at our next Adult Council meeting in January 2017. There was consensus that more involvement of the Council and aligning of priorities was a positive move.	Bring information related to Outpatient services (capacity, funding recipients, allocation plans, previous priorities, etc.) to the January 2017 Council meeting. Mui Mui will access the latest report on the state's efforts to intercede in Human Trafficking for the November meeting.
DMHAS Update Karin Haberlin	• Connecticut's SFY 16 budget is now reported to have a $170 million deficit • Additional cuts are possible but probably won't be known until after the election	

	• Of the 2200 state employee layoffs initially predicted, only about half have happened, and it is unclear whether additional layoffs will occur or be offset by increased retirements • Budgets which include a 5% reduction have been submitted and the Governor will be able to act on these • New materials are available on the DMHAS website and on data.ct.gov, including new videos and a variety of reports. Karin demonstrated these new materials on the internet.	
Block Grant Update Susan Wolfe	• Currently working on MHBG and SABG and Synar annual reports due in December • All priorities selected in the last Block Grant Application are on track to be achieved • At present, we have interim project officers for both CSAT and CMHS • A phone conference with NRI concerning possible phenX measures for FEP occurred • We are in the process of recalculating MOE using "net" rather than "gross" numbers which we anticipate will reduce the amount of the MOE shortfall substantially. This recalculation goes back several years and will apply to both the SAPT and the CMHS MOE calculations. We have been in ongoing conversations with SAMHSA about MOE and they have been positive about these efforts to address our MOE issue.	
Other Business Marcia DuFore	The schedule for 2017 meetings has been created. Susan wanted to make everyone aware that we were unable to get exactly the same room schedule at CVH as last year and some meetings were scheduled for Page Hall room 365. The reason for not sending the schedule for 2017 already was because there had been a discussion in the last Joint Council meeting about changing the meeting time and it had been agreed that a doodle poll would be conducted to see if there was a better time. Chrishaun will send out the doodle poll to the Adult Council members and then send the results to Mary Cummins who will use them to create a doodle poll for the Children's Council	Susan will send out the 2017 meeting schedule
Meeting Adjourned		
Next Adult meeting:	January 18, 2016 from 12:30 PM – 2:30 PM, Room 365, Page Hall, CVH	
Respectfully submitted:	Susan Wolfe, Ph.D.	

DRAFT

Joint DMHAS/DCF Council Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, June 8, 2017, 2:00 – 4:00 PM	
Location:	Connecticut Valley Hospital, Page Hall – Room 217	
Attendance:		
Members Present:	Lisa Jameson, Eileen Bronko, Janice Bendall, Nicki Richer, Janine Sullivan-Wiley, Nannette Latremouille, Peggy Ayer, Kati Mapa, Magda Lekarczyk, Ellen Econs, Irene Herdon, Laura Watson, Marjorie Foster, Maureen O'Neil-Davis, Doriana Vicedomini, Marcia DuFore, Mary Martinez, Mary Cummins	
Staff Present:	Tim Marshall, Jim Siemianowski	
Guest	Nan Arnstein	
AGENDA ITEM		***ACTION***
Review of Minutes	The minutes were accepted without correction.	
Specialized Treatment Early Psychosis (STEP) Program Vinod Srihari, Director CT Mental Health Center	Specialized Treatment Early in Psychosis (STEP) Program is one of two programs that DMHAS has set aside funding for intervening with people experiencing first episode psychosis (FEP). On the children's side for first episode psychosis, DCF discontinued CBITS, a trauma informed school-based program, and initiated a contract with ABH to identify potential FEP clients using databases. Dr. Vinod Srihari from the CT Mental Health Center was scheduled to present a power point on this program but unfortunately had to cancel. The presentation with Dr. Srihari will be rescheduled.	
Block Grant Update Jim Siemianowski	• Each year DMHAS and DCF go through a process where they submit allocation plans to OPM and in turn the Commissioners of DMHAS and DCF present these plans to the legislature. • This year the full block grant application and plan is due September 1, 2017. • Highlights of the plan will be presented during the individual DMHAS and DCF meetings next month. • **DMHAS -** has a new Center for Substance Abuse Treatment officer. An informal visit was conducted last month. DMHAS has been informed that next year will be a formal week long site visit with the Center for Substance Abuse Treatment, Center for Mental Health Services, and Center for Substance Abuse Prevention in CT at the same time to look at how the money is spent, tracked and if the rules and regulations are being followed. • **Note – Schedule the joint meeting in 2018 to coincide with the site visit from the Center for Substance Abuse Treatment officer.** **DCF -** CBHAC annually selects priority areas they want to support. This year they chose Access to Comprehensive Array of Services to support family and youth engagement, health promotion, prevention and early identification. DCF's priority areas based on those	

	for the block grant were family and youth engagement, suicide prevention, workforce development and childhood trauma. These topics aligned with CBHAC priorities and are areas that DCF continues to fund with block grant dollars.	
DMHAS Update Jim Siemianowski	• Through a competitive procurement process, DMHAS is replacing a state operated community mental health center with a private not for profit in Torrington. This is a large RFP, just over 6 million dollars. A bidder's conference was held and the due date for submissions is June 23, 2017. They hope to begin contracting with the new replacement agency on August 1, 2017 and to be fully operational by October 1, 2017. • The provider that is awarded this contract is expected to provide a full continuum of services; mobile crisis, jail diversion, and outpatient. They will assume responsibility for young adult's residential program for two young adult assertive community treatment teams and a recovery and wellness program. DMHAS is requiring that in order to get the award the provider must have a substance abuse license and a mental health outpatient psychiatric license. • An application was just completed for additional funding for services that are comparable to what DMHAS does in their behavioral health homes (BHH). They are trying to better integrate physical health and behavioral health so the BHH's are doing care coordination. • DMHAS is also working on a grant from CSAT which deals with pregnant and post-partum women who are using substances. They are currently evaluating data and looking at some of the communities with the greatest need. Funding from this would help support multi-disciplinary care teams doing family treatment for substance use.	
DCF Update Tim Marshall	• The legislative session ended with no budget and now the agency is determining what the potential consequences in the short term are with or without cuts. • There are practical issues with contracts, fiscal departments and maintaining current contract funding levels, renewals and amendments. They are waiting for the process to play out to determine if there will be any changes or reductions. • Unrelated to the block grant, DCF also has a federal System of Care grant. A site visit on this grant was conducted and the results of the report issued were positive with good recommendations.	

Other Business **Doodle Poll – Meeting time of the Joint Council:** Mary Cummins	A doodle poll regarding the time of this meeting was sent to the DMHAS participants. They came up with several days and times that could potentially work during the week but unfortunately do not work for the CBHAC participants. This all stems from the current meeting time of 2:00 – 4:00 not being a good time for parents with children. A time more convenient for parents with children might also help with increasing participation on the child side. Mary Cummins will discuss this with Susan Wolfe to determine what makes sense to bring to leadership. In a previous meeting council members discussed their choice of meeting topics. The top three were: • Expand the use of peers for the child and adult systems. • Same day access across child and adult systems and its impact on waits for appointments. • Expand/support suicide prevention across the life span including bridge signs, etc.	
Next Joint Meeting:	September 14, 2017 at CVH Page Hall, Room 217 from 2 – 4 pm.	

Joint BHPC Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, March 9, 2017 - 2:00 PM – 4:00 PM	
Location:	CVH, Page Hall, Room 217	
Attendance:		
Members Present:	Doriana Vicedomini, Janice Bendall, Peggy Ayer, Kati Mapa, Lisa Jameson, Marcia DuFore, Janine Sullivan-Wiley, Nannette Latremouille, Eileen Bronko, Nikki Richer, Ingrid Gillespie, Tom Steen, Kristie Barber, Margaret Watt, Ellen Econs, Lisa Jameson, Mui Mui McCormick	
Staff Present:	Susan Wolfe, Jim Siemianowski, Tim Marshall, Chrishaun Jackson	
Guest	Nan Arnstein	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes were discussed and a potential project idea was identified as missing from the list: "analyzing other models for medication management" in the section entitled "Role of the Planning Council". The minutes were accepted with this change.	
Block Grant Update Susan Wolfe Jim Siemianowski	• DMHAS and DCF are actively working on the 2018-2019 Combined CMHS and SAPT combined block grant application which will run about 500 pages when completed. • There has been some substantial turnover of staff at SAMHSA. The new CSAT project officer for CT is Courtney West and the new CMHS project officer for CT is Frank Cruzata. Both have been provided an orientation to the DMHAS service system. • Tentative schedule of presentations for Council meetings in 2017 is as follows: o April (Adult) meeting: Regional priority setting reports and statewide report of priorities o June (Joint) meeting: STEP program by the Clinical Director Vinod Srihari o July (Adult) meeting: presentation of 2018-19 Block Grant Application and Plan (DCF will conduct the same presentation for CBHAC) o September (Joint) meeting: Brass Tacks by Nydia Rios-Benitez o October (Adult) meeting: membership; Psychiatric services in the DOC by Craig Burns, MD o November (Joint) meeting: ADPC recommendations • An Orientation to the Behavioral Health Planning Council will be scheduled just before an upcoming Joint Council meeting for all new and interested parties • The Regional Priority Setting Reports and the Statewide Priority Setting Report have been posted on the DMHAS website and are open to public comment • The status of MOE for SAPT was reviewed for both 2016 where additional data was requested and 2017 which is due for submission March 15, 2017. • SAMHSA is scheduling a formal site visit for April 2018. They have changed the format of the site visits so that a team comprised of CMHS, CSAT and CSAP reviewers all arrives to conduct the review together.	Schedule a meeting of the Joint Council during the SAMHSA site visit in April 2017.

	In addition to a documents request, they will meet with DMHAS staff, conduct program visits, review fiscal services, and they want to meet with the Behavioral Health Planning Council. It was agreed that we should schedule the April meeting during the time of the SAMHSA site review.	
Updates: DMHAS And DCF Jim Siemianowski Tim Marshall	**DMHAS Update**: • Budget o DMHAS is looking to privatize services - The Torrington and Danbury offices are in the Governor's budget to be closed and purchased privately. o Substance Abuse beds at Blue Hills and 21 detox beds are scheduled to go to CVH. o Twenty one Residential beds will be privatized; keeping only 5 Rehab beds available in Hartford o 16 inpatient beds at Capitol Region will go to CVH o 3 YAS State Operated residential programs will close and be privatized o RACs and Regional Mental Health Boards may be consolidated o No lay-off option – employees at offices that are closing will be offered positions • Grant application was submitted for Medication Assisted Treatment/Expanding Opioid Treatment for $5 ½ million each year for 2 years. This is a non-competitive grant that is designed to help increase access to medication assisted treatment, provide prevention, increase access to naloxone, and increase the number of buprenorphine prescribers within community health centers. Money has been allocated for all states. **DCF Update:** • DCF has been involved in a lawsuit for the past 20 years. Negotiations and agreements over this period had resulted in consolidating the required outcomes from 22 to 6. An agreement between the plaintiffs and DCF was reached such that DCF could be considered to have met the desired outcome to the satisfaction of the plaintiffs. However, the legislative approval required for the agreement was denied because the legislature concluded that DCF funding needed to be frozen. Due to the legislatures' decision: • DCF is accountable for ALL 22 Outcomes as well as other standards that are of great cost to the state • Proceedings that were once held in Judge's chambers are now in full court • The Attorney General is now representing DCF, where DCF was previously allowed to represent itself DCF is in a "holding" pattern; anticipating 10% cuts and further reductions as everyone else. Internally, DCF has been instructed to move forward as if the agreement was upheld and continue to focus and work diligently on the 6 consolidated outcomes in the agreement. DCF Administration has had meetings with every manager in the state outlining where priorities need to be in order to achieve an exit from the current external oversight.	

Role of the Planning Council: **Priority Project Proposals**	After the Block Grant conference last year there have been several discussions in the Planning Council meetings regarding the role of the Planning Council and how to maximize its usefulness. At the previous Joint Council meeting, the Council brainstormed some possible project ideas and it was recommended that Council members bring additional ideas to this meeting. Following is the list of possible project ideas from last and the current meeting: • Linking systems: how OPCCs should be linked with other services • An observation that severe ADHD in parents is impacting youth with BH needs as parent's dysregulation is so severe • What does same day access look like in regions? Differences, needs and similarities and how wait days are impacted. LMHAs within 1 year should all have same day access. On the child side, ECCs have same day but impact on CGC for this to occur • Workforce development and need for psychiatric support. Should CT ACESS MH present to the Council as an example of practice? • Suicide prevention across the lifespan and embedded in the system • Analyzing other models for medication management • Language access for all programs • Develop telemedicine to expand access to culturally/linguistically competent services • Expand phone individual/group therapy referred to as "conference call therapy" • Add signs for bridges about where to get help if in distress • Support suicide prevention activities • Provide stipends for young adults to work with other young adults using super advocate graduates • Provide support/funding for smoking/vaping cessation • Pilot a program of insurance reimbursement for Recovery Support Specialist services • Expand use of peers throughout the child and adult system • Coordinate various suicide/overdose support groups/data/best practice guidelines/grief recovery/website/help people make connections and share their experiences • Infuse strengths/assets into assessments and treatment plans and RMHB evaluations It was agreed that prioritization from among the proposed projects on this list should be conducted electronically. Council members will be asked to pick their top 3 priorities from this list and the results will be shared electronically with everyone. In choosing the top 3, council members are to assume "low cost – no cost". At the June meeting, the results of the prioritization will be reviewed and further discussed.	Susan will ensure that an electronic survey is conducted on the list of proposed projects and will send the results electronically when compleated.
Doodle Poll	There is continued interest by some in moving the time of the Joint Behavioral Health Council meeting to earlier in the day because of conflicts for some parents with children coming home from school. However, so far there is no ideal time identified. Results of the Adult Council poll will be sent on to CBHAC.	Susan will send the results to Doriana

Other Business	No other business	
Next Meeting	June 8, 2017 at CVH Page Hall Room 217 from 2 – 4 pm.	

Joint BHPC Meeting
Meeting Minutes

Meeting Day/Date:	Thursday, September 8, 2016 - 2:00 PM – 4:00 PM	
Location:	CVH, Page Hall, Room 217	
Attendance:		
Members Present:	Irene Herden, Doriana Vicedomini, Manuel Maldonado, Janice Bendall, Peggy Ayer, Kati Mapa, Lisa Jameson, Marcia DuFore, Kathy Flaherty, Janine Sullivan-Wiley, Nannette Latremouille, Craig Burns, MD, Eileen Bronko, Allyson Nadeau, Nikki Richer	
Staff Present:	Susan Wolfe, Jim Siemianowski, Tim Marshall, Chrishaun Jackson, Mary Cummins	
Guest	Josina James, Mallory Fergione, David Vaughan, Lawrence Haber from IOL; Nan Arnstein from Creative Arts for Developing Minds	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Introductions **Review of Minutes**	Minutes were discussed and accepted without changes.	
Potential Program - IOL (DMHAS 10% set-aside) Josina James Mallory Fergione David Vaughn Lawrence Haber	The early psychosis program started at IOL in 2004, but additional support from DMHAS has allowed it to expand. While early intervention in psychosis may be expensive, savings are realized over time. IOP is the core of the treatment and includes skills groups & process groups exclusively for young adults. A variety of tracks are also available (Potential Track with cognitive and social remediation, social recovery and outreach; Dual Diagnosis Track; Right Track with an LGBT specialty). The average length of stay is 6 – 8 weeks. Transitioning back to the community is challenging so outreach, support and education of the client and family are offered. Services are provided 2 -3 times/week and services of IOL are available as back up. Much of their program is based on the RAISE model. Going to where the client/family needs services is a critical aspect of the program and promotes engagement. Multi-family Therapy groups and community presentations are offered. Clinicians handle client engagement, evaluations and treatment. Case Managers help clients connect to services and address barriers (housing, transportation). Vocational Counselor works on evaluating and developing school/work skills. Peer counselors offer support, advocacy and knowledge through lived experience. Psychiatrist offers engagement and medication management. The case management and vocational services and also the mobility of these services are not covered services. At present there are 24 active clients, and there are no barriers to expanding that case load, except that they do not take clients from the Yale catchment area. Clients without insurance will not be turned away and referrals can come from anywhere. Expansion of the set-aside from 5% to 10% permitted: cognitive remediation services by a psychologist, use of a psychiatric rating scale as a progress measure, Vocational Counseling services expanded to full time,	Power point shown and hand-outs distributed

	mobility of the psychiatrist, and the ability to accept clients without insurance.	
Block Grant Update Susan Wolfe	The Allocation Plans were accepted at the Public Hearing on August 31st. The DMHAS Commissioner was only asked one question. DCF noted that they were asked more questions. The mini-application due September 1st was submitted on time and DMHAS is now responding to a revision request from the CMHS project officer concerning expenditures and identifying state department representatives on the planning council. There has not been any definitive answer yet to the waiver request to SAPT for the MOE. Next due to SAMHSA will be the Annual Reports for December 1st and the Annual Synar Report for December 31st.	
Updates **DMHAS** Jim Siemianowski	The focus has been on the budget. There continue to be reductions and cuts that impact employment, residential and case management services. DMHAS was awarded two grants: One for Medication Assisted Treatment and another for Prevention aimed at reducing prescription opioid abuse. ➢ Med Assisted grant is focused on three areas: Willimantic/Windham, Bristol/New Britain, and Torrington. The three areas were selected based on opioid admission and overdose death data. This grant begins September 1st in the amount of 1 million dollars per year for 3 years. ➢ The Prevention grant is for planning, marketing, and implementing strategies that will reduce drug abuse within the state. This grant requires that case managers conduct "aggressive" outreach by connecting to Emergency Departments to identify individuals who have overdosed and attempt to connect them to treatment. This grant was for $350,000 per year for 3 years.	
Updates **DCF** Tim Marshall	The Legislative report is due next Thursday for an update on the overall Behavioral Health System. This will be the 3rd update report following the Newtown tragedy. The first report was on October 1, 2014, the second was done in 2015. DCF continues to work on the Juvenile Justice plan to close the training school (JCT). Big issues are Truancy and Referrals. DCF continues to have challenges with the ongoing fiscal crisis and trying to minimize how providers will be affected.	
BG Conference Findings Marcia DuFore Doriana Vicedomini	One of the conference sessions was on enhancing the efficacy of planning councils. Both Colorado and New Jersey had reported ways to make more of a difference in their states. Colorado purchased a system called "Go-Digital" which is software that simplifies and organizes the priority setting process. The cost of this is about $3,000. New Jersey was able to make a difference with boarding homes through advocacy efforts. It was mentioned that SAMHSA has unexpended TA funds that could be used related to these areas of interest.	Doodle poll to be conducted to determine if there is a preferred time

	It was pointed out that there were limits to how much the planning council could do because of historic funding patterns and other barriers. The time that the Joint Council meets was also identified as problematic for parents of school-aged children. Others felt that if people wanted to participate they would find a way regardless of what time the meetings were held. It was agreed to do a survey to find out if another time would be preferable. Feeling that participation on the planning council mattered and was valued was identified as the important aspect of this discussion. Continuing this discussion going forward is planned.	for the Joint Planning Council meetings. Include discussion of these topics in upcoming agendas.
Other Business	No other business	
Next Meeting	November 10, 2016 at CVH Page Hall Room 217 from 2 – 4 pm.	

Joint BHPC Meeting
Meeting Minutes

Meeting Day/Date:	November 10, 2016 – 2:00 to 4:00 PM	
Location:	CVH, Page Hall, Room 217	
Attendance:	Doriana Vicedomini, Janice Bendall, Marcia DuFore, Peggy Ayer, Lisa Jameson, Tom Steen, Janine Sullivan-Wiley, Katie Mapa, Margaret Watt, Irene Herden	
Staff Present:	Jim Siemianowski, Susan Wolfe, Tim Marshall, Mary Cummins	
Guest:	Nan Arnstein from Creative Arts for Developing Minds	
AGENDA ITEM	***DISCUSSION***	***ACTION***
Welcome and Announcements	Minutes from September 8, 2016 were accepted without changes	
Status of Block Grant Priorities	• The handout lists all the current priorities, the first year goals and whether or not those goals have been achieved based on the measures designed to assess them. The handout also identifies the required goal areas. • DMHAS: Susan reviewed priorities 1- 6 and 11 from the handout. All goals have been achieved. It was recommended that DMHAS coordinate internally on the work being accomplished on Healthcare disparities since both EQMI and Colleen Harrington with BHP are examining this area. It was also recommended related to prescription opioid prevention that data be collected on all the training being conducted if possible. • DCF: Tim and Mary reviewed priorities 7-10. Suicide prevention activities were described. MATCH is part of a 5 year project and 80% of clinicians are certified in this trauma informed care. Evidence-based practice workforce development was discussed.	Handout titled *Block Grant Update: 2017 Annual Reports* distributed and reviewed.
Block Grant Update	• The SAPT and CMHS annual reports are due 12-1-16. A summary of what is required for the annual reports is contained on pages 2 and 3 of the handout, following the priorities update. • The annual synar report is due at the end of December and requires the Governor's signature. • The next combined biannual block grant application and plan is due September 1, 2017.	Handout titled *Block Grant Update: 2017 Annual Reports* distributed and reviewed.
DMHAS Update Jim and Susan	• DMHAS is working with SAMSHA to address the Maintenance of Effort (MOE) Issue for SAPT resulting from changes in funding streams in CT. Dollars that used to flow through DMHAS to DSS now go directly to DSS as a result of Medicaid expansion and the ACA. MOE is not an issue for MHBG, but is for SAPT. DMHAS continues to work with SAMHSA to obtain a waiver.	

	• DMHAS budget is unclear as the amount of deficit is still unknown. Budget option is pending. • No new grants. Last grant applied for was opioid use and access to Naloxone. This grant starts December 1, 2016.	
DCF Update **Tim and Mary**	• The budget remains a concern. The recent CT election changes some champions of BH. • DCF was able to significantly reduce the number of outcomes needed for the consent decree from 22 to 6. Two should be resolved in next six months. DCF plans to resolve the last 4 outcomes by 2018. It began in 1989.	
Role of Planning Council **Marcia** **Doriana** **Susan**	Chairs want to see real impact by council on next application due September 1, 2017. Discussion was held with general agreement that all would come to the next meeting prepared to propose ideas for a project/priority for the council to address. State attendees reminded council that only levels of care that are not insurance reimbursable should be funded with block grant dollars. It was also pointed out that the council is an advisory body and the block grant dollars have parameters and priorities from other bodies as well. Ideas were discussed and will be on the table for the next meeting. Ideas proposed include: • Linking systems: how OPCC's should be linked with other services • An observation that severe ADHD in parents is impacting youth with BH needs as parent's dysregulation is so severe. • What does same day access look like in regions? Differences, needs and similarities and how wait days are impacted. LMHA's within 1 year should all have same day access. On the child side ECC's have same day but impact on CGC for this to occur. • Workforce development and need for psychiatric support. Should CT ACESS MH present to council as an example of practice? • Suicide prevention across the life span and embedded in the system.	
Other Business	• Only a handful of members responded to the Doodle Poll about changing the time of the JBHPC meeting. We will resend it so please respond if you haven't. • Please note the January ABHPC meeting will be in a new room (#365) of Page Hall.	
Next Meeting:	Joint Planning Council March 9, 2017 CVH 2-4 Page Hall Room 217	

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Margaret (Peggy) Ayer	Parents of children with SED		151 Pond Road North Franklin CT, 06254-1224 PH: 860-642-4348	msayer7@comcast.net
Kristie Barber	Others (Not State employees or providers)	South Central CT Regional Mental Health Board	CT Valley Hospital, Shew-Beers Hall Middletown CT, 06457 PH: 860-262-5027 FX: 860-262-5028	execdir@rmhb2.org
Janice Bendall	Others (Not State employees or providers)		48 Barlett Hollow Road Middletown CT, 06457 PH: 203-645-3602	jnbendall@comcast.net
Eileen Bronko	Parents of children with SED	Northwest Regional Mental Health Board	34 Fairfield Court Naugatuck CT, 06770 PH: 203-723-0875	ebronko1@snet.net
Craig Burns	State Employees	Dept of Correction (DOC)	24 Wolcott Hill Rd Wethersfield CT, 06109 PH: 860-692-6262 FX: 860-730-8287	craig.burns@ct.gov
Joan Cretella	Family Members of Individuals in Recovery (to include family members of adults with SMI)		225 Beach Street West Haven CT, 06516 PH: 203-933-4272	
Deron Drumm	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Advocacy Unlimited, Inc.	300 Russell Road Wethersfield CT, 06019-1346 PH: 860-667-0460 FX: 860-666-2240	ddrumm@mindlink.org
Marcia DuFore	Others (Not State employees or providers)	North Central Regional Mental Health Board, Inc.	151 New Park Avenue Hartford CT, 06106 PH: 860-667-6388 FX: 860-667-6390	mdufore@ncrmhb.org
Ellen Econs	State Employees	Bureau of Rehabilitative Services	410 Capitol Ave Hartford CT, 06134 PH: 860-418-6770 FX: 860-418-6690	ellen.econs@ct.gov
Kathy Flaherty	Others (Not State employees or providers)	Connecticut Legal Rights Project	CVH, Shew-Beers Hall Middletown CT, 06457 PH: 860-262-5033 FX: 860-262-5035	kflaherty@clrp.org

Tarsha Galloway	Parents of children with SED		289 Ferry St New Haven CT, 06513 PH: 203-503-1395	ndreams0729@aol.com
Sarah Gauger	State Employees	State Dept. of Aging (SDA)	55 Farmington Ave Hartford CT, 06105 PH: 860-424-5233	sarah.gauger@ct.gov
Ingrid Gillespie	Others (Not State employees or providers)	Connecticut Prevention Network	c/o LFCRAC Stamford CT, 06901 PH: 203-391-7914 FX: 203-967-9476	igillespie@communities4action.org
Susan Graham	Parents of children with SED		141 High St Thomaston CT, 06787 PH: 860-309-4322	sgraham141@yahoo.com
Lorna Grivois	Family Members of Individuals in Recovery (to include family members of adults with SMI)		586 Westchester Road Colchester CT, 06415 PH: 860-267-6083	grivois620@comcast.net
Gabrielle Hall	Providers	Beacon Health Options	500 Enterprise Drive Rocky Hill CT, 06067 PH: 860-707-1016	gabrielle.hall@beaconhealthoptions.com
William "Bill" Halsey	State Employees	DSS	25 Sigourney St Hartford CT, 06106-5033 PH: 860-424-5077 FX: 860-424-4812	william.halsey@ct.gov
Josephine Hawke	Parents of children with SED	FAVOR, Inc.	185 Silas Deane Highway Rocky Hill CT, 06067 PH: 860-563-3232 FX: 860-563-3961	jhawke@favor-ct.org
Mary Held	Parents of children with SED		6316 Lithcfiled Turnpike Bethany CT, 06524 PH: 203-441-1887	mary.held@togetherweshine.org
Brenetta Henry	Parents of children with SED		73 Governor Street East Hartford CT, 06108	brenetta.henry@yahoo.com
Irene Herden	Others (Not State employees or providers)		49 Bogue Lane East Haddam CT, 06423-1442 PH: 860-873-1999 FX: 860-873-1999	evherd@comcast.net
Mui-Mui Hin-McCormick, MS, LMLT	Others (Not State employees or providers)	CT Asian Pacific American Affairs Commission	18 - 20 Trinity Street Hartford CT, 06106 PH: 860-240-0080	Mui.Mui.Hin-Mccormick@cga.ct.gov
Lisa Jameson	Parents of children with SED		112 Bell-Aire Circle Windsor CT, 06096 PH: 860-623-5790	lisajameson22@gmail.com
Nannette Latremouille	State Employees	Connecticut Valley Hospital	P.O. Box 351 Middletown CT, 06457 PH: 860-262-5970 FX: 860-262-9334	nannette.latremouille@ct.gov
			450 Capitol Avenue	

Magdalena Lekarczyk	State Employees	CT Office of Policy and Management	Hartford CT, 06106 PH: 860-418-6405 FX: 860-418-6490	magdalena.lekarczyk@ct.gov
Kati Mapa	Others (Not State employees or providers)	Eastern Regional Mental Health Board	401 West Thames Street Norwich CT, 06360 PH: 860-886-0030	kmapa.ermhb@gmail.com
Tim Marshall	State Employees	DCF	505 Hudson St Hartford CT, 06105 PH: 860-550-6531 FX: 860-556-8022	tim.marshall@ct.gov
Mary M. Martinez	Family Members of Individuals in Recovery (to include family members of adults with SMI)		7 Mary Shepard Place, Apt 710 Hartford CT, 06120 PH: 860-719-5080	mryadvcomm35@gmail.com
Debbie McCusker	Parents of children with SED		35 Maywood Street Waterbury CT, 06704 PH: 203-757-7569	jamesmccusker@sbcglobal.net
Ebony McDaniel-Gladding	State Employees	Court Support Services Division (CSSD)	Solnit Children's Center South Campus Middletown CT, 06457 PH: 860-704-4014	ebony.mcdaniel@jud.ct.gov
George McDonald	Parents of children with SED		P. O. Box 2617 Hartford CT, 06146 PH: 860-794-6283	
Carol Meredith	State Employees	DMHAS - Prevention	410 Capitol Ave Hartford CT, 06134 PH: 860-418-6826 FX: 860-418-6792	carol.meredith@ct.gov
Scott Newgass	State Employees	State Dept of Education (SDE)	25 Industrial Park Rd Middletown CT, 06457 PH: 860-807-2044 FX: 860-807-2127	scott.newgass@ct.gov
Maureen O'Neill-Davis	Parents of children with SED	Attachemnt Trauma Network	1811 Mountain Rd Torrington CT, 06790 PH: 561-762-4747	maureenod65@gmail.com
Commissioner Raul Pino	State Employees	CT Department of Public Health	410 Capitol Avenue Hartford CT, 06106 PH: 860-509-7101 FX: 860-509-7111	Raul.Pino@ct.gov
Nikki Richer	State Employees	DMHAS - Young Adults	CVH Middletown CT, 06457 PH: 860-262-6995 FX: 860-262-6980	nikki.richer@ct.gov
Barbara Roberts	Family Members of Individuals in Recovery (to include family members of adults with SMI)		42 School Street Woodbury CT, 06798 PH: 203-263-3250	Barbara114@sbcglobal.net

Thomas Steen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Capitol Area Substance Abuse Council	3 Barnard Lane Bloomfield CT, 06002 PH: 860-286-9333 FX: 860-286-9334	tsteen@casac.org
Janine Sullivan-Wiley	Others (Not State employees or providers)	Northwest Regional Mental Health Board, Inc.	969 West Main Street Waterbury CT, 06708 PH: 203-757-9603 FX: 203-757-9603	jsw@nwrmhb-ct.org
Cindy Thomas	Parents of children with SED		64 Lilac Street New Haven CT, 06500 PH: 203-901-9911	cindythomas1370@yahoo.com
Peter Tolisano	State Employees	Dept of Developmental Services (DDS)	460 Capitol Ave Hartford CT, 06106 PH: 860-418-6086	peter.tolisano@ct.gov
Benita Toussaint	Parents of children with SED		45 Niles St Hartford CT, 06105 PH: 860-249-4806	toussassaintbenita@yahoo.com
Ofelia Velazquez	Parents of children with SED		180 Broad St Hartford CT, 06114 PH: 860-313-9130	ovy4252@yahoo.com
Doriana Vicedomini	Parents of children with SED		9 Kingfisher Lane Suffield CT, 06078 PH: 504-259-4327	DMV35@aol.com
Laura Watson	State Employees	Department of Housing	505 Hudson Street Hartford CT, 06106 PH: 860-270-8169 FX: 860-706-5741	laura.watson@ct.gov
Margaret Watt	Others (Not State employees or providers)	Southwest Regional Mental Health Board	1 Park Street Norwalk CT, 06851 PH: 203-840-1187 FX: 203-840-1926	mwatt@swrmhb.org
Cara Westcott	Providers	United Community and Family	UCF Health Center, The Meadows Center Norwich CT, 06360-2315 PH: 860-892-7042 FX: 860-886-6124	cwestcott@ucfs.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	49	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	15	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	10	
Total Individuals in Recovery, Family Members & Others	33	67.35%
State Employees	14	
Providers	2	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	16	32.65%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Persons in recovery from or providing treatment for or advocating for substance abuse services	17	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Discussions about the block grant occur on an ongoing basis with the behavioral health planning council. The 18/19 Application and Plan was presented separately to the Adult Behavioral Health Planning Council on July 19, 2017 and to the Children's Behavioral Health Advisory Council in June 2017.

The Planning Council recommended changing the proposed priority indicator related to enhancing transportation connected to the 1-800-563-4086 number (which residents with opioid use disorder can call if they want to be connected to services) from the number of rides to detox to the percentage of people receiving transportation who were accepted/admitted to services. Investigation into this matter revealed that clients would not be receiving rides unless they had been accepted for services so the decision was made to retain the original indicator of the number of rides to detox. The Planning Council recommended modifying the priority related to expanding recovery support services to be inclusive of not just recovery coaches in hospital EDs, but all peer support services for both mental health and substance use and felt that these services should not be "siloed", but integrated so that all peers provided services for both mental health and substance use. As this appears to be a much larger system issue, the Planning council decided to send a

memo to the Commissioner instead. For the primary prevention priority on reducing marijuana use among adolescents, the Planning Council recommended changing the indicator from adolescent use of marijuana to perception of risk of both adolescents and adults. This recommendation was investigated to see if it was possible to access such data. The Director of Prevention provided the requested data which is from the NSDUH 2013-2014 for Connecticut, so the indicators will be changed to those recommended by the Planning Council, namely, adolescent (12-17) and parent (26+) perceptions of risk of monthly smoking of marijuana. There was also a recommendation to add a priority related to engagement of clients across all levels of care. A measure of success could be the number of clients that attend more than one session of treatment. The problem with this proposal is that no strategies were identified for effecting change on this particular topic, so it will not become a priority. However, in discussions with the DMHAS Director of Evaluation, Quality Management and Improvement, data is being collected on engagement and the data can be presented/discussed with the Planning Council at a future meeting.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	Yes No
b)	Posting of the plan on the web for public comment?	Yes No
c)	Other (e.g. public service announcements, print media)	Yes No
	If yes, provide URL:	

Footnotes: